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REDUCING HEALTH CARE COSTS: EXAMINING HOW TRANSPARENCY CAN LOWER SPENDING AND EMPOWER PATIENTS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

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ON

EXAMINING REDUCING HEALTH CARE COSTS, FOCUSING ON HOW TRANSPARENCY CAN LOWER SPENDING AND EMPOWER PATIENTS

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C O N T E N T S

STATEMENTS

TUESDAY, SEPTEMBER 18, 2018

REDUCING HEALTH CARE COSTS: EXAMINING HOW TRANSPARENCY CAN LOWER SPENDING AND EMPOWER PATIENTS

Tuesday, September 18, 2018

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Cassidy, Young, Murkowski, Scott, Murray, Casey, Murphy, Warren, Kaine, Smith, and Jones.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. Good morning. Senator Murray is on her way, but she's asked that I go ahead and begin, because she has double duty today. The fact is she's here.

[Laughter.]

The CHAIRMAN. You know, there was—many years ago, Senator Everett Dirksen of Illinois was a little bit theatrical. Senator Murray is not theatrical. But Senator Dirksen was, and when he would speak at an event, he would wait in the back of the room until he was introduced and people would begin the applause. And then he would walk very slowly to the front to extend the applause for a long period of time.

[Laughter.]

The CHAIRMAN. Senator Murray has double duty today. She's managing the Labor, Health, and Human Services Appropriations Bill on the floor, and she's here. So I want to recognize that and compliment her on that piece of legislation, because it has a variety of good things in it, and, again, I believe, it takes an important step in increasing funding significantly for biomedical research at the National Institutes of Health. She and Senator Blunt have led that effort, and I and others support it. It sets priorities within the budget limits, and it's good for our country.

The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Senator Murray and I will each have an opening statement. I'll introduce the witnesses. Then we'll hear from the witnesses, and Senators will have five minutes to ask questions.

As any American—even the Secretary of the Department of Health and Human Services—knows, it can be difficult to find out how much a simple healthcare test will cost before a doctor's visit. Secretary Azar recently told the story of his doctor ordering a routine echocardio stress test. He was sent—the Secretary was sent down the street and admitted to the hospital where, after a considerable effort on his part, he learned the test would cost him $3,500. After using a website that compiled typical prices for medical care, he learned the same test would have cost just $550 in a doctor's office. Secretary Azar said that consumers are so in the dark, they often feel powerless.

The Internet has made it easier for consumers to know more about what they want to purchase before they actually buy it. You can easily read an online review and compare prices for everything from a coffeemaker to a new car. This is true for everything else but not for healthcare. The cost of healthcare has remained in a black box.

Any one of us who has received a medical bill in the mail has wondered what we're actually paying for. For years, patients were more or less okay with that, because insurance companies and the government paid most of the bills. However, as premiums have increased, more Americans are covered by plans with high deductibles, which means they're often paying lower monthly payments for their premiums in exchange for spending more out of pocket with they go to the doctor or fill prescriptions.

According to the Kaiser Family Foundation, half of all single covered workers in 2017 had a deductible of at least $1,000, which is Kaiser's threshold for a high deductible. This is an increase from 34 percent in 2012. And because Americans themselves are footing more of their healthcare bills, more are showing an interest in shopping around, as Secretary Azar did when he had his heart test.

Today's hearing is the fourth in a series on reducing the cost of healthcare. It's an opportunity to learn how we can improve what information is easily available about the cost and quality of healthcare so patients can make their best healthcare decisions for their families, themselves, and their wallets. Without better information, healthcare stays in that black box, making it hard for Americans to be good consumers, make good decisions, and pay reasonable amounts for necessary healthcare.

Senator Paul, a Member of our Committee, has talked about how, with an elective surgery such as LASIK, a patient is more likely to call doctors' offices to find the best price, calling an average of four different doctors to find the best price for that corrective eye surgery. As patients have shopped around for LASIK, the price started to dramatically decrease. It's gone down 75 percent over the last 15 years, according to Senator Paul.

The black box also disguises the quality of care. This is important, because we think often that high cost equals high quality. For example, Stephen Joel Trachtenberg, who has spoken freely about raising tuition to raise the profile of George Washington University while he was president, has said, quote, "People equate price with the value of education," unquote. While the price of tuition, unlike healthcare, is easily available on universities' websites, deciphering the quality of education and healthcare is hard.

Improving transparency in healthcare prices and quality is an area where the private sector and states are largely leading the charge. For example, medical centers like the Surgery Center of Oklahoma and St. George Surgical Center, one of our witnesses today, list the prices for the surgeries they offer on their website so patients know up front how much their surgeries will cost.

Healthcare Bluebook, represented by another witness, is a tool that helps employees find the best price for the highest quality care in their area using their employer-sponsored insurance. This is a useful tool to lower costs, because, for example, the amount a patient pays for cataract surgery in Memphis can range from as little as $2,000 to more than $8,000.

In 2017, the State of Maine passed a bill requiring health insurers to split the savings with a patient if the patient shops around and chooses a doctor that is less than the average price the insurer pays. In Oregon, the state compiles data on insured residents and uses this information to run a tool similar to Healthcare Bluebook that shows—that allows patients to compare the cost of procedures used at different hospitals.

While the private sector is largely leading the charge in making healthcare information more easily available, the Federal Government can also play a role, and witnesses today can inform us about steps that we can take. Secretary Azar told the story of finding out the price of his heart test in a speech, announcing that the Administration would focus on increasing price transparency. For example, in April, Centers for Medicare and Medicaid Services Administrator Seema Verma announced that by January 2019, hospitals that participate in Medicare or Medicaid must list their current standard prices online.

In an age when you can compare different prices and check a dozen reviews when shopping for a new barbeque grill, Americans should be able to know more about the cost of their healthcare.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you, Mr. Chairman. Thank you for comments on the Labor appropriations bill, that I will be leaving shortly to be back on the floor to help manage that, and I appreciate your support for that, as well as much of our work here.

Thank you to all of our witnesses today. I'm especially looking forward to hearing from Ms. Giunto about her amazing work. Her organization is the Washington Health Alliance, and it's from my home state. I'm very glad to see you.

The Alliance has actually been an incredible advocate for quality and value in healthcare and taken on very impressive projects to increase transparency and arm our patients and employers and healthcare providers across our state with information that they can use to provide patient care. One report from the Alliance details how improvements to our state's health system could help more kids get checkups, more women get screened for breast cancer, and more diabetics get the treatment that they need.

Another refutes the myth that higher cost or a bigger facility necessarily means better care for patients, and a report that looked at overused treatments and low-value care found that nearly half

of our patients received that care. That adds up to $282 million in unnecessary healthcare spending, or $1 out of every $3 that were spent. That's consistent with testimony our Committee has heard over the last few months from experts across the country. Your work shows exactly why transparency is such an important tool for patients, for providers, and governments who are looking to lower healthcare costs and increase value and efficiency and quality.

Unfortunately, instead of taking steps towards greater transparency, President Trump has only taken steps towards greater chaos by sabotaging our healthcare system and making it harder for families to get access to the care they need and the information that actually helps them get the care they—that helps with their healthcare decisions.

Look at the Navigator Program, which provides clarity and transparency and guidance to people who are trying to understand our complex system and get health insurance for their families. This program is especially important for patients who don't speak English as a first language and people who are less familiar with the healthcare system. Last year, the Administration cut Navigator funding nearly in half, slashing it from $63 million to $36 million, and just two months ago, they did it again. After dragging their feet and giving very little heads-up to the organizations to adjust, they cut funding by about two-thirds. It's now down to $10 million.

In addition to cutting funding, they cut the number of Navigator entities required per state down to one, and they announced the Navigator organizations serving a state can be located virtually anywhere, even across the country, far away from those who need the help. In our stabilization hearings last year, this Committee heard just how valuable navigators with a physical presence and cultural competency can be, especially for tribal communities. We can expect these communities to be hit particularly hard by President Trump's sabotage of the Navigator Program.

But while President Trump's decision to shortchange that program and deny navigators adequate time to prepare for those changes is disappointing, it is not surprising. Sabotaging the healthcare system and raising costs for families have become standard practice for this Administration. From day one, President Trump has made every possible effort to restrict access to healthcare and roll back protections for preexisting conditions, despite people across the country rejecting his backwards agenda.

Last year, people stood up and spoke out against the mean-spirited Trump Care Bill which would have hurt families by spiking premiums, gutting Medicaid, and denying protections for preexisting conditions. In the end, the people succeeded, and President Trump's sabotage bill failed.

However, instead of learning his lesson and listening, President Trump decided to continue to sabotage healthcare from the Oval Office, like when he handed back control to the insurance companies, making it easier for them to sell junk insurance that discriminates against older people and women and people with preexisting conditions, or when after all his campaign talk of being for law and order, he actually ordered the Justice Department not to defend the law of the land and take the highly unusual step of refusing to defend preexisting condition protections in the courts, or when he

nominated a judge for the Supreme Court, hand-picked for his willingness to strike down healthcare protections for millions. At every step, President Trump has moved healthcare in this country in the wrong direction.

So while I'm glad to know there is bipartisan agreement about the importance of transparency in helping ensure quality and value in healthcare, I hope we can find common ground to reject the sabotage and address the damage and skyrocketing prices it has caused. Transparency alone is absolutely not enough. A drug company being transparent about its exorbitantly expensive drugs doesn't help the people who can't afford it. An insurance company being transparent about its discrimination based on age, sex, and preexisting conditions doesn't help people get the care they need.

So today, I look forward to hearing from our witnesses about how transparency can help us move forward, but for the sake of families in Washington state and across the country. I hope the conversation doesn't stop there.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

We'd like to ask the witnesses to summarize their testimony in about five minutes so Senators can ask questions. I want to welcome each of our four witnesses.

The first, Ms. Leah Binder, is President and Chief Executive Officer of the Leapfrog Group in Washington, DC, a nonprofit representing employers and other purchasers of healthcare that are working on ways to improve safety and quality in hospitals. Leapfrog Group developed a system to grade hospitals across the country based on quality and safety and post this information on a public website. Formerly, she was vice president at the Franklin Community Health Network in Maine.

Next we'll hear from Mr. Bill Kampine, Co-founder and Senior Vice President of Client Analytics at Healthcare Bluebook in Nashville, Tennessee. Healthcare Bluebook is an online tool to help individuals find high-quality healthcare options at fair prices. Prior to this, he served in a number of executive roles at Healthways, an organization specializing in disease and lifestyle management. Previously, he was a healthcare economist and consultant.

Senator Murray, would you like to introduce the next witness?

Senator MURRAY. Thank you. I would, and I'm very pleased to introduce again, as I mentioned, Nancy Giunto. She's the Executive Director of the Washington Health Alliance. I had the opportunity to meet with Nancy in my office just about a year ago here about some of the projects that her organization is working on, and as I learned then and I suspect we'll hear about today, her organization has done some incredible work to help provide information and transparency that can improve healthcare in our state and possibly serve as a model to many others.

Her experience in healthcare before leading the Alliance includes the National Institutes of Health, the American Hospital Association, Intermountain Healthcare, and at Providence Health and Services.

So, Nancy, it's great to see you again. Welcome back to Washington, DC. Thank you for making that long trip out here. We appreciate it.

The CHAIRMAN. Thank you, Senator Murray.

Next is Mr. Ty Tippets, Administrator of the St. George Surgical Center, a physician-owned ambulatory surgical center in rural southern Utah. In 2014, the surgical center began posting cash prices online for all its surgical procedures so that patients could know the cost of their care up front. In addition to accepting cash, St. George also accepts Medicaid, Medicare, and commercial insurance for the services provided.

Welcome again to all of our witnesses.

Ms. Binder, let's start with you.

STATEMENT OF LEAH BINDER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE LEAPFROG GROUP, WASHINGTON, DC

Ms. BINDER. Thank you, Chairman Alexander and Ranking Member Murray. I'm very appreciative of the opportunity to be here with you today.

I'm Leah Binder from the Leapfrog Group. We are a nonprofit. We are independent, national, based here in DC. We represent employers and other purchasers of health benefits, attempting to improve healthcare in part through transparency by publicly reporting on the performance of hospitals and other health settings on safety and quality. We've been doing this for 18 years, so we have a great deal of experience with transparency and have found it to be a very successful method of improving care and lowering costs.

We function not only at the national level, but also regionally, with 40 business groups on health across the country who represent almost every state in the country, and two of those states, I want to note, are Washington state and also Tennessee. They are two of our more notable states.

In Tennessee, we have not one, but two business groups on health that are very active, one of which our outgoing chair, Christy Travis, heads up—the Memphis business group on health—and also Healthcare 21 in Nashville is very active. From the beginning of Leapfrog, both of them have been active. In addition, HCA based in Nashville is 100 percent transparent. They report entirely to Leapfrog—all of their hospitals do—the only health system of its size to do so. So it's a state that we think quite highly of and is very much a vibrant part of the Leapfrog movement.

In Washington state, the Boeing Company has been a very formidable and active member of Leapfrog since day one. They formed Leapfrog. They're one of the key partners in doing so. And, also, we awarded our highest award ever awarded to a hospital by Leapfrog to the Virginia Mason Medical Center as a top hospital of the decade.

So it is a pleasure to be here with you and to tell you just a couple of things about why transparency has been so effective and what we need to do in the future to maintain and improve on that record. Leapfrog collects data from hospitals. We ask on behalf of employers, including those coalitions across the country who have members who are also purchasers and consumers. We ask them to report to us data that cannot be collected from any other source. This includes, for example, C-section rates by hospital. That is not available at the national level by hospital except through Leapfrog,

and that is voluntarily provided by almost 2,000 hospitals through Leapfrog.

We also grade hospitals on how safe they are. For that, we use data we collect, but also data we get from CMS that is publicly reported. It's an A, B, C, D, or F on how safe hospitals are. All of the data we collect is available for free to the public.

One key issue for us is that price transparency is never enough. It will backfire if it is only price transparency. That's because bad care is never a bargain, and, unfortunately, it is possible to encounter bad care in this country, and, in fact, errors and accidents in hospitals, safety problems, are considered the third leading cause of death in this country. So it's actually quite common. Some hospitals and some health centers are better at protecting their patients than others, and consumers deserve to know which is which. That's why we grade the hospitals.

What we found is that consumers do, in fact, use the grades. We've seen incredible growth in the use of that information to drive behavior by consumers. We've also seen a change in how hospitals perceive their own role in appealing to consumers and in putting their needs first. We've seen an incredible uptick by hospitals in trying to achieve that A and putting patient safety first, including putting their grade right on the list of bonus incentives for their C suite. We have seen everything happen as a result of transparency.

We are moving to start to collect data on ambulatory surgical centers where there is relatively little quality data publicly available that consumers need. The majority of surgeries are now performed in either outpatient or ambulatory surgical centers. That is very important to us.

So our next step is to work with the Administration to expand the availability of what is available publicly by CMS and others. We are concerned that CMS seems to be prioritizing the burden on providers. The burden on others, taxpayers, the American public, employers also needs to be considered and should be the priority. So we look to you to help us to expand transparency.

Thank you.

[The prepared statement of Ms. Binder follows:]

PREPARED STATEMENT OF LEAH F. BINDER

Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee, thank you for the opportunity to share the perspective of employers and other large purchasers of health care on the importance of transparency to improve American health care. It is an honor to have been invited to participate in today's discussion. My name is Leah Binder. I am the President and CEO of The Leapfrog Group, an independent national nonprofit movement founded in 2000 with support from the Business Roundtable, representing hundreds of the leading purchaser and employer organizations across the country calling for transparency of the safety, quality and affordability of care. We also advocate for value based payment reform as proud members of the DRIVE campaign, in partnership with the ERISA Industry Committee, the Pacific Business Group on Health, and many Fortune 500 employers.

We are one of the few organizations that both collects and publicly reports by hospital on safety and quality on a national level, thereby bringing a unique perspective to the importance of transparency. In conjunction with 40 business groups on health that serve as regional Leapfrog leaders across the country, we advocate for transparency, and "leaps forward" in safety and quality of care. We grade hospitals with an A, B, C, D, or F on how safe they are for their patients.

Senator Alexander, I am pleased to say Tennessee is one of the most active states in the Leapfrog movement, with not one but two business groups on health leading the campaign for Leapfrog participation and employer use of Leapfrog data: the Memphis Business Group on Health and HealthCare 21 Business Coalition in Nashville. Also in Nashville is the headquarters of HCA, a healthcare system with an unparalleled commitment to transparency, including 100 percent of their hospitals reporting on quality publicly through Leapfrog for over a decade. Senator Murray, I'm also pleased to tell you to say Washington State is a place of pride for our movement. The Boeing Company was one of our leading founders and Seattle's Virginia Mason Medical Center earned Top Hospital of the Decade—our most prestigious hospital award. States in the top five in the country for prevalence of "A" hospitals in every single update of our Safety Grade are Maine and Massachusetts. And just this month, two new business groups joined as Leapfrog leaders in each of their states, one in Louisiana and one in Alabama. We have history and relationships in states represented by every Member of this Committee.

In this written testimony, I will describe Leapfrog's main programs to improve transparency in health care, offer from our experience how transparency drives improvement and cost reduction, and summarize why transparency has emerged as an urgent issue for consumers as well as employers and other purchasers. I will offer our perspective on the defining elements of effective transparency, and three general policy principles and recommendations for Committee consideration.

Leapfrog's Programs to Improve Transparency

Leapfrog is the gold standard in health care transparency in the United States. We collect data on hospital quality and safety through the annual Leapfrog Hospital Survey, using evidence-based questions reviewed and supported by peer-reviewed literature and review by top experts. Leapfrog Regional leaders, typically business groups on health, ask hospitals to voluntarily report the information. Leapfrog makes it freely available to the public.

Almost 2,000 hospitals representing two-thirds of the nation's hospital beds reported last year. Through the Survey, employers and other purchasers as well as the public at large can monitor important issues of quality and safety that are not publicly available by hospital from any other source. For instance, we report on caesarean-delivery rates, medication safety, and pediatric patient satisfaction. That data is used by all national health plans, hundreds of purchasers, and many publishers of performance data. In 2019, we will launch a Survey on quality and safety of hospital outpatient surgery and Ambulatory Surgery Centers.

As mentioned above, Leapfrog publishes the Leapfrog Hospital Safety Grade, an A, B, C, D, or F assigned to over 2,600 general hospitals in the United States twice a year. This is assigned to hospitals whether they voluntarily complete our Survey or not. The Hospital Safety Grade rates hospitals on their success preventing errors, accidents, and infections, and provides consumers information to begin their research when selecting a hospital. We calculate the Grade from 27 measures of safety derived from the Centers for Medicare & Medicaid Services (CMS) data and other sources including our own Survey if the hospital reports. We update the research and the grades every six months.

We find significant variation among hospitals on the prevalence of safety hazards, and that is costly in lives and dollars. In one analysis of our Hospital Safety Grades, researchers from Johns Hopkins Medicine estimated that 33,000 lives would be saved annually if every hospital were as safe as "A" graded hospitals. The researchers found that purchasers spent an average of $8,000 more for every inpatient visit as a result of patient safety problems. To help purchasers estimate lives and dollars at risk for their own employees, we provide a free calculator which you may find enlightening for estimating dollars and lives lost among your constituents.

Transparency Drives Improvement and Lowers Costs

A stakeholder consensus report by the Lucian Leape Institute of the National Patient Safety Foundation concluded "if transparency were a drug, it would be a blockbuster." The report outlined how transparency jump-starts improvement from within health systems—when clinicians communicate candidly to each other—and outside health systems, when information is shared with the public.

One example the report cited came from Leapfrog, a case where transparency about maternity data drove dramatic improvement nationally. Specifically, after Leapfrog began publicly reporting hospital rates of early elective deliveries—deliveries scheduled early without a medical reason—rates began plummeting. Until the

data was transparent, progress lagged—despite efforts by some of the most influential organizations in the country, like the American College of Obstetricians and Gynecologists (ACOG) and the March of Dimes. Reporting rates by hospital galvanized the efforts of those organizations, hospitals, and others, so that the national average went from 17 percent in 2010 to lower than 3 percent today, saving countless babies and mothers from harm.

We also see the power of transparency to drive improvement in patient safety. The measures that have been prominently reported by CMS, Leapfrog, and others, such as central line infections, have shown dramatic improvement nationally. Measures that have not been reported publicly or less prominently reported show less improvement. Extensive peer-reviewed literature suggests that the cost of complications and errors is highly significant; one study saw as much as $39,000 per infection for private purchasers. We conclude that driving improvement through transparency generates significant cost-efficiency as well as better care.

Consumers and Payors Want Transparency

At Leapfrog we see rapid growth in consumer interest in our ratings and ratings from other organizations. When we update our ratings every six months, at least 3,000 news outlets across the country cover them, and hundreds of local radio stations broadcast news items or interviews about the new hospital ratings. The breadth of coverage increases with every update. And perhaps as significantly, hospitals pay close attention to how consumers perceive their performance. Many hospitals tell us senior executive compensation is tied in part to the Hospital Safety Grade, or clinicians are waging a major campaign to improve infection rates or readmissions because a quality rating or ranking made the local newspaper. Most patient safety advocates find this highly gratifying, because traditionally there appeared to be few if any consequences for hospital leaders that did not put a priority on patient safety and quality. Transparency changes that.

Part of the interest in health care ratings comes from the growth of ratings throughout American culture, now ubiquitous in all industries and driven by a digital economy. But that's not the whole story, because health care doesn't typically stay on trend with the rest of the economy. Few doctors use email to reach patients, much less social media, for instance, and fax machines have disappeared almost everywhere except doctor's offices and hospitals. The growth in health care ratings comes in large part from the advent of high deductible health plans (HDHPs), coupled with tax-protected Health Savings Accounts or other arrangements to cover the deductible. Such plans were first authorized in 2003, with passage of the Deficit Reduction Act during the administration of President George W. Bush. Subsequently high-deductible plans accelerated in adoption during the Obama administration, authorized as part of state exchanges in the Affordable Care Act.

Employers embraced HDHPs, in part as a way to put the brakes on their health costs and avoid the so-called "Cadillac Tax" in the Affordable Care Act. With the threat of the Cadillac Tax, it is no longer a competitive disadvantage for a company to offer an HDHP. In 2004, a handful of Americans had a high deductible plan, while today one in three workers are covered by one. This is a very significant shift, impacting our health care system and indeed our entire economy.

HDHPs are different from more traditional health plans, like PPOs or HMOs, where consumers pay one fixed copay for each physician visit or prescription even if their plan has a deductible. With HDHPs consumers pay the whole bill from the doctor or the hospital, and they shoulder the full cost of each prescription, until they spend past the deductible. But deductibles are so high most people never reach it in a given year, so they are paying every dime of their care all the time. This prompts them to think differently about their role in selecting the doctor, approving a service, or taking a drug. They ask new questions: do I really need this $2,000 test? Is there a drug option cheaper than this prescription costing $500?

This kind of consumer engagement creates a market and markets fuel competition, which can reduce costs. Indeed, a number of studies as well as actuarial reports cite HDHPs as a factor when national health spending growth slows. The idea that spending growth in health care could ever slow suggests something dramatic about the infrastructure of our health care system, which has stubbornly resisted cost control over decades. Employers report savings of varying significance when they shift to HDHPs, and not one ever found that HDHPs raised their health spending. That alone is a breakthrough for employers who have longed for some relief from the seemingly endless escalation in health costs.

There are many debates about the merits of HDHPs and whether people get adequate care when covered by one. But HDHPs are a reality and policymakers and

business leaders alike should work together to improve their effectiveness. The challenge for all of us is to shape HDHPs in a way that works best for the health and economic well-being of Americans. Employers have worked to accomplish that by subsidizing or in some cases fully funding Health Savings Accounts, offering second-opinion services and help navigating the system, and providing direct support like telemedicine and onsite clinics.

But employers always aim to preserve the fundamental principle behind HDHPs: that individuals should have incentives to "shop" for health care services, which over the long run will be key to improving quality and costs. For that reason, we must ensure that people covered by HDHPs, as well as all Americans, can access information they need to make decisions. Though we have made progress on transparency—and Leapfrog was founded to help push that progress along—still today consumers have far too little information on quality and price to make truly informed decisions. That makes living with an HDHP much more difficult, and limits the effectiveness of consumer behavior and opinion to drive positive change. It is hard for markets to gravitate toward the best care at the best price when information is inadequate.

Effective Transparency: Two Defining Elements

Before turning to Leapfrog's recommendations on policy principles for improving transparency, it is important to specify what Leapfrog means by transparency. In health care, too often transparency is compromised by smoke and mirrors meant to protect sensitive special interests. Other industries in the American economy are accustomed to high levels of market transparency, so Leapfrog turns to those examples to define the level of transparency we seek in health care. Without a true level of transparency, no market cannot optimally drive change in quality and cost-effectiveness. Here are the two defining elements of effective market transparency.

1. *Government releases good data, the private sector motivates consumers to use it.* The two roles are different.

- Government agencies should make data available and remove barriers to getting that data. They should also ensure data protects patient privacy and protects providers from miscalculations and unscientific misrepresentations.
- What government agencies should avoid is excessive focus on communicating that data for public use. There are many talented enterprises prepared to assemble data into formats usable by the many different kinds of consumers. Government communications of data tend to be politicized, tiptoeing around sensitive findings, and not as interesting in presentation because it's not what agencies do best. The private sector will compete to present data in ways that interest people.

2. *Data should allow people to compare services among various providers.* This sounds obvious, but it's not the norm in health care reporting. For example:

- For political reasons, government agencies often deliberately obscure meaningful variation that exists between providers. Hospital Compare, the consumer-facing website produced by CMS, for instance, reports about 90 percent of hospitals as average on every measure. This contradicts what we know from enormous bodies of research: that variation among providers is a hallmark of our health care system. They are not all the same.
- Measures of performance are also developed separately for different kinds of facilities, so consumers seeking one particular procedure cannot compare apples-to-apples an Ambulatory Surgery Center against a hospital if both offer that procedure. Measures should be standardized to meet the needs of consumers, not the facility-level nuances providers deal with.
- MACRA allows physicians to pick and choose which measures of performance they will be held to. This has no value for consumers comparing among practice options, and little value to purchasers negotiating value contracts.

Three Policy Principles for Expanding Transparency to Improve Care and Reduce Costs

Principle One: Safety First

Avoidable harm from safety problems is the third leading cause of death in the U.S. according to BMJ. One in four patients admitted to a hospital experiences some form of harm. According to our research and data, some hospitals have two or three times more incidences of harm than other hospitals, and the average employer pays nearly $9,000 on average per hospital admission for medical errors.

The public cares deeply about this problem—as long as we define it correctly. In our market research, we find that people comprehend the term "patient safety" as fire safety or security guards. But when we clarify our interest in errors, infections, and accidents, they become very emotional about the enormity of the problem. Virtually every individual we interviewed or focus-grouped has a story about an infection or mistake they or a loved one suffered.

Some of the most critical safety information that consumers and purchasers care deeply about comes from the Centers for Disease Control and Prevention (CDC), from information reported by hospitals as well as other facilities including long term care facilities and ambulatory surgery centers to a CDC program called the National Healthcare Safety Network (NHSN). Among the important information NHSN collects and risk-adjusts are some of the most common and deadly infections. Unfortunately, CDC shields the rates data from public view. That should change.

The good news is that CMS requires hospitals that accept Medicare to publicly report NHSN infection rates for five distinct types of infections, and then makes the NHSN rates publicly available—though not necessarily by individual hospital, because health systems are permitted to report one rate for the whole system. Then last Spring, CMS issued a proposed rule to remove all of those infection rates as well as a number of other critical patient safety measures from the Inpatient Quality Reporting program, created under the Bush Administration for the purpose of public reporting. The reason given was that it was too burdensome for hospitals to report the data. After a story about this broke in USA Today, there were hundreds of consumer and purchaser advocates who came forward to advocate continued transparency of this patient safety information. We were pleased when CMS said in final rulemaking they will preserve full reporting of the measures, and made a strong statement of commitment to transparency.

The Leapfrog Group is the business community's strategy to get around the barriers and threats to transparency that exist in current federal policy. Hospitals may voluntarily make their infection data public through the Leapfrog Hospital Survey, by simply giving permission to Leapfrog to draw down their infection data from NHSN. Leapfrog reports infections by individual hospital, never by system. This method adds no burden to hospitals for reporting infections. And it gives peace of mind to purchasers and consumers that if government agencies try to hide critical information in the future, we at least have an alternative voluntary mechanism to preserve it.

Recommendations

- Americans shouldn't need Leapfrog to gain access to critical safety data collected by our public agencies. NHSN data should be made public by the CDC, reported by individual hospital, and all federal agencies should lean toward transparency.
- CDC could also require more entities to submit infection data and they should publicly report those rates as well. These include Ambulatory Surgery Centers, pediatric hospitals, and other facilities that deliver important services to millions of Americans. CDC should work with CMS and the Agency for Healthcare Research and Quality (AHRQ) to assure they are reporting the same measure across settings so consumers can have apples-to-apples comparisons among places that offer the same service.
- CDC should also make public its surveillance of other key safety issues, such as antibiotic stewardship at hospitals, and do the same surveillance at ASCs and other facilities.

Principle Two: Price Transparency Alone Can Backfire

We appreciate and commend HHS Secretary Alex Azar for pursuing price transparency for services delivered in hospitals and health systems. This is important

leadership. But we add one proviso: for purposes of improving health care and controlling its costs, price transparency alone is meaningless or worse, misleading enough to drive up healthcare costs and harm quality. That's because the quality of care determines the spending. A procedure may be offered at a good price, but it is no bargain if 1) the patient suffers from an infection or medical error, 2) the procedure wasn't needed in the first place, or 3) the procedure is poorly performed and has to be corrected. The National Academy of Medicine estimates that one-third of health spending is wasted, mostly on one of those three issues.

For example, a hospital with a high risk-adjusted Cesarean section rate will cost more even if the price of each procedure seems low. Price transparency in this case should be coupled with transparency about C-section rates and other maternity quality data. Leapfrog monitors a standardized rate of C-sections and finds substantial variation, where one hospital may have twice the rate of another down the street without a medical reason. Indeed, variation applies for virtually every service provided in health care, even including services many believe are uniform in practice, such as MRIs. A misdiagnosis on an MRI will lead to unneeded or even unsafe treatments down the line, so the actual cost far exceeds whatever price the MRI provider charged. Consumers, payors, and employers deserve to have both cost and quality data available to them so they can choose the best care at the best price.

Recommendation:

- Enact policies that expand price transparency, but require that quality data be reported alongside pricing.

Principle Three: Don't Kill The Measurement

In rulemaking CMS reiterated a goal expressed by a stakeholder report published by the National Academy of Medicine: trim measures of provider performance into a "parsimonious set of measures." In the dictionary, the word "parsimonious" means "frugal" or "cheap." The National Academy of Medicine did not recommend parsimony in their earlier report about $1 trillion in wasted spending (mentioned above), but frugality is the marching order for measurement. CMS appears to have aligned with this goal in its campaign called "Meaningful Measures."

The movement for measurement in health care is bedrock to the advancement of transparency. And like transparency, it is still in its infancy. It has been little more than a decade and a half since hospitals reported quality and safety measures through CMS, AHRQ fostered measure development, and the National Quality Forum (NQF) began endorsing measures. This is a fragile and pioneering effort, difficult and not lavishly funded.

It has enabled us to provide valid and meaningful information to the public and payors. While a national strategy on measurement is worthwhile, parsimony should be reserved for the real waste in health care, not the measurement that will ultimately root it out.

Recommendations

- We need a national strategic framework for measurement that pivots on public and payor interest. NQF, provider stakeholders, and measure developers can then assure availability of optimal measures within each category. The CMS Meaningful Measures initiative defines categories as set by a variety of providers and other stakeholders, but the categories should be driven primarily by the priorities of patients, not preference of industry. This is how measurement takes place in other industries; an assessment of broad categories of consumer interest is fundamental to reporting quality of cars, mutual funds, appliances, and virtually every good or service. Through this framework it is feasible to trim duplicative measures and identify gaps, but without that consumer-driven purpose we risk undermining effective transparency and allowing special interests to obscure performance reporting.
- Public and private sector transparency efforts should be coordinated. Public sector efforts should build on, and not duplicate, best practice transparency strategies and vice-versa. As one example, CMS, the federal employees benefits program, the Veterans Administration (VA), and the Defense Health Agency could have hospitals to report data to Leapfrog Hospital Survey. At no financial cost, this would drive a stronger, more aligned market for quality and cost-efficiency. Already

we have seen inroads in this area, as VA hospitals are considering reporting to the Leapfrog Hospital Survey, and the Defense Health Agency is including Leapfrog maternity data in two programs to improve hospital care for military families.

- Policymakers should expand innovations in how we measure. To date, policy has focused on development of valid measures of performance, which is helpful. But other techniques for comparing performance could be built or expanded, such as patient surveys to assess clinical outcomes and complications, automatic tabulation of performance through electronic medical records, and public release of traditionally hidden records of performance, such as accreditation reports.
- Include data on all providers Americans entrust their lives to. There is a long list of types of providers exempt from reporting to CMS or CDC. These include (to varying extents) military hospitals, VA hospitals, children's hospitals, critical access hospitals, specialty hospitals, and facilities in US territories such as Guam and Puerto Rico. Exemptions should be rare, but they are commonplace.

The Leapfrog Group applauds and supports the Senate HELP Committee for your bipartisan leadership on health care. Employers and other purchasers are ready and willing to work with you.

[SUMMARY STATEMENT OF LEAH F. BINDER]

CHAIRMAN ALEXANDER, RANKING MEMBER MURRAY, AND MEMBERS OF THE SENATE HELP COMMITTEE:

Thank you for the opportunity to share the perspective of employers and other large purchasers of health care on the importance of transparency to improve American health care. The Leapfrog Group is an independent national nonprofit movement founded in 2000 with support from the Business Roundtable, representing hundreds of the leading purchaser and employer organizations across the country calling for transparency of the safety, quality and affordability of care

We are one of the few organizations that both collects and publicly reports by hospital on safety and quality on a national level, thereby bringing a unique perspective to the importance of transparency. In conjunction with 40 business groups on health that serve as regional Leapfrog leaders across the country, we advocate for transparency, and "leaps forward" in safety and quality of care. We grade hospitals with an A, B, C, D, or F on how safe they are for their patients.

A stakeholder consensus report by the Lucian Leape Institute of the National Patient Safety Foundation concluded "If transparency were a drug, it would be a blockbuster." We find that true in our experience, as our public reporting by hospital galvanized dramatic improvements in quality and cost-efficiency, from maternity care quality to hospital acquired infections. Today we see rapid growth in consumer interest in our ratings, as well as unprecedented responsiveness from hospitals aiming to improve their Hospital Safety Grade.

With the dramatic growth in High Deductible Health Plans, which have helped slow the growth in health costs, people need information to make decisions about health care as never before. Transparency relies on government to release good data that shows variation among providers. But government does not need to motivate consumers to use it—that is a separate role and private sector enterprises will compete for consumer interest.

We recommend three main policy principles:

1. Put Safety First. Patient safety problems are third leading cause of death and a major, if often hidden cost driver. It nullifies equations of value and quality or good pricing, and concerns consumers deeply. CDC should make its data on infections and other safety issues public.

2. Price Transparency Alone Can Backfire: Couple it with quality ratings, because quality determines spending. A procedure may be offered at a good price, but it is no bargain if 1) the patient suffers from an infection or medical error, 2) the procedure wasn't needed in the first place, or 3) the procedure is poorly performed and has to be corrected. The National Academy of Medicine estimates that one-third of health spending is wasted, mostly on one of those three issues.

3. Don't Kill the Measurement. The movement to create and endorse good measures is relatively young and fragile, yet already there are efforts

to cut it in the name of "parsimony"—frugality not applied to the actual excess measures are designed to root out. We need a framework for measurement that pivots on consumer needs, not industry preference. And we need more public-private alignment to get and use the right measures, including more federal engagement with Leapfrog and efforts like ours.

The Leapfrog Group applauds and supports the Senate HELP Committee for your bipartisan leadership on health care. Employers and other purchasers are ready and willing to work with you.

The CHAIRMAN. Thank you, Ms. Binder.

Mr. Kampine.

STATEMENT OF BILL KAMPINE, CO-FOUNDER, SENIOR VICE PRESIDENT, CLIENT ANALYTICS, HEALTHCARE BLUEBOOK, NASHVILLE, TN

Mr. KAMPINE. Chairman Alexander, Ranking Member Murray, and Committee Members, thank you for the opportunity to testify today. Price and quality transparency is an important topic, and it's key in order for consumers and employers to get more value out of our healthcare delivery system.

I'm going to start today with a brief story. It's actually about the first Bluebook consumer. It's my co-founder, Dr. Jeff Rice. About 10 years ago, Jeff's young son needed an outpatient foot surgery. It wasn't a very complex case, but it was sort of a rare procedure. So Jeff does his homework, finds a specialist in this area, and he schedules the surgery at a nearby hospital.

Because Jeff has a high deductible, he calls the hospital to get an estimate of the price. You can imagine how that conversation went. The hospital says, "We don't know," and "Why are you asking?" So Jeff explains that he's got a high deductible, and the hospital agrees to do some research and to get back to him with a price estimate. So about 10 days later, Jeff gets a call, and while the hospital can't provide an exact price, they have an in-network estimate for him. So the in-network estimate is a minimum of $15,000. Jeff thinks to himself that's a little expensive for a one-hour outpatient surgery. So he calls his doctor and asks, "Is there another facility where we can schedule the surgery?" The doctor says, "Absolutely." Same quality, more convenient for Jeff and his family. So Jeff calls the second facility.

Does anybody want to take a guess at what the second price was? It wasn't $15,000. It was $1,500. Same doctor, same quality, more convenient for Jeff and his family, over $13,000 difference in price.

I'd like to tell you that this story is an artifact of a different era, but that's not true. Our data tells us that every day across the United States, consumers face precisely this level of price variability. This is why price and quality transparency are so important, and it's why we created Healthcare Bluebook. It should be easy for employees and their family members and our neighbors to understand what they should reasonably pay for care, compare providers, and get better value for themselves.

Each year, employers and consumers through out-of-pocket costs spend about $1.5 trillion. Conservatively, about a third of that is non-acute shoppable procedures. Based on the work we do with employers, if consumers were to use more cost-effective providers

within their existing network, both consumers and employers could save about half of that, and that's $250 billion returned to the economy.

On the consumer side, what is the number one cause of bankruptcy in the United States? Medical bills. Leah mentioned it. The number three cause of death is medical errors or poor quality. In this room, we talk about cost and quality on a large scale. I can tell you what—the job consumers are trying to solve is pretty simple. It's safety and savings, and there's an important role for transparency in helping consumers meet that need.

From 10 years of working with consumers and employers, what I know is that when consumers understand that they should shop for care and they have access to transparency tools, they'll use those tools to compare cost and quality. What I also know is that consumers who shop for care before receiving treatment are two to three times more likely to select cost-effective or high-quality providers for themselves, and, of course, this has a tangible impact on the consumer. They can save hundreds of dollars on common services, like diagnostics and imaging, and they can save thousands of dollars on surgeries, both inpatient and outpatient, and employers have a significant impact on lowering their overall plan costs as well.

As the Committee turns its attention to policy initiatives that can make transparency more broadly available to U.S. consumers, I would offer the following considerations. The first is that independent transparency providers, along with our employer partners, have led innovation in this area for over a decade. Independent solutions need to be at the center of transparency because they are free from conflicts of interest that can arise with our other industry stakeholders.

Second, we are in need of improved quality measures for outpatient care. Leah talked a little bit about this. Leapfrog is doing some great work in this area. I support greater access to CMS encounter level data for outpatient surgeries in both the hospital outpatient venue and in the ambulatory surgery center setting. The reason this is important is so that we can understand and compare quality for the same surgery performed in those two settings. Access to this data will further outpatient quality measurement initiatives and improve overall transparency for consumers.

Lastly, a growing body of research suggests that when hospitals buy hospitals or hospitals acquire outpatient centers or physician practices, the result is higher prices. I encourage Congress to be vigilant of the impact that consolidation has on prices and to promote policies that foster competition, which I believe in the long run are in the interest of our consumers.

I thank the Committee again for the opportunity to testify today, and I look forward to questions.

[The prepared statement of Mr. Kampine follows:]

PREPARED STATEMENT OF BILL KAMPINE

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for this invitation to speak with you today to share thoughts on how improved price and quality transparency reduces cost for employers and consumers, improves the healthcare experience for patients and fosters a more efficient, competitive healthcare delivery system.

My testimony is drawn from my experience as Co-Founder and Senior Vice President of Analytics at Healthcare Bluebook. We established Healthcare Bluebook in 2007 with a simple purpose: to protect patients by exposing the truth about prices and empowering consumers to make better choices.

Bluebook is now one of the largest independent providers of healthcare price and quality transparency solutions to large self-insured employers, state and municipal governments, employee benefit trusts and third-party administrators. Millions of insured members use Healthcare Bluebook's shopping solution to understand what they should reasonably pay for care in their area, compare in-network providers on both cost and quality, and save on their out-of-pocket healthcare expenses.

Bluebook price and quality transparency tools are accessed by employers and consumers in all 50 states and every metropolitan area in the US.

The Impact of Hidden Costs

Hidden price and quality variability have a significant impact on both patient health and affordability. In the US, medical bills are the number one cause of bankruptcy, and medical mistakes (i.e. poor-quality care) are the third leading cause of death. When patients don't understand what care should cost or lack the ability to compare providers, they frequently overpay for common healthcare services by as much as 2X–10X. When patients don't have access to outcomes-based quality information, they choose poor performing doctors or facilities, increasing their risk of complications, readmission and death.

Lack of transparency also has a significant cost for employers and our broader economy. Roughly $1.5 trillion of our annual US healthcare expenditure is paid for by employers or directly through consumer out-of-pocket costs (NHE 2016).

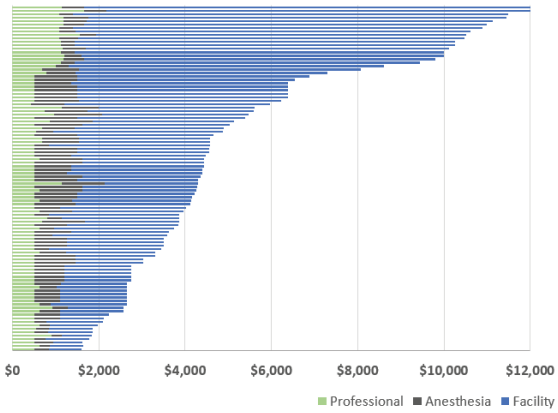
Conservatively, shoppable non-acute healthcare services account for one-third, or $500 billion, of the $1.5 trillion total. Based on our analysis of commercial healthcare claims data, when consumers have the tools to shop for care, compare providers on cost and quality, and choose better value in-network providers, both consumers and employer plan sponsors can save 50 percent of the costs on these shoppable services. In the commercial insurance market alone, this would return $250 billion back to our economy.

Additional savings are also available to the Federal Government. While there is lower price variability in Medicare rates when compared to commercial payments, Medicare beneficiaries choosing a lower price venue for care can reduce cost by as much as 50 percent for some imaging and outpatient procedures.

Price and Quality Variability

In-network prices for common shoppable outpatient and inpatient procedures vary by 2-10x, without an accompanying difference in quality or outcome for the patient. Moreover, high price variability is extremely consistent. We observe this level of variability in every US metropolitan area, and across insurance company networks.

Figure 1: Price Variation: South Florida Cataract Surgery Prices



Sample of 100 cataract surgeries. The price represents the commercial allowed amount, or the amount paid after insurance discount is applied.

For any given service, the single largest component of cost is the facility fee or location where care is delivered. Variability in the facility price, not physician fees, drive overall price variability. For consumers, where they choose to receive care will have a significant impact on price.

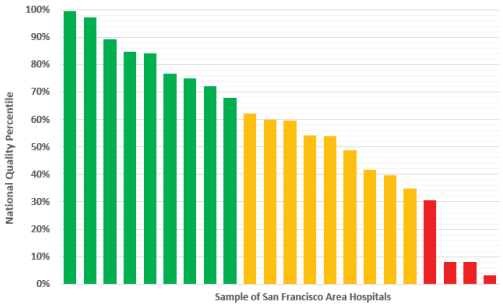
Inpatient quality demonstrates similar variability both within and across hospitals. Bluebook uses CMS data to independently evaluate patient outcomes in 36 clinical areas for over 5,000 US acute care hospitals.[1] Our composite quality scores compare a hospital's outcomes in each clinical area (joint replacement, stroke care, etc.) benchmarked against all other US hospitals. A similar analysis is used to evaluate physician-specific outcomes.

Based on our analysis of the national quality data, we consistently find the following:

- Hospital outcomes in most metro areas exhibit a wide range of performance, from the top 25 percent nationally to the bottom 25 percent nationally. Patients must be able to differentiate between high and low performers.
- Outcomes for different clinical departments within the same hospital also exhibit significant variation. Patients cannot rely on brand to make global quality determinations.
- When combining clinical quality and Bluebook price data, we do not observe any correlation between cost and quality. Patients cannot rely on price as a proxy for quality.
- Selecting a high-quality hospital does not guarantee a high-quality physician. Patients must be able to independently evaluate both facility and physician quality.

[1] Bluebook composite quality ratings include individually scored dimensions for mortality, complications, safety events and unanticipated readmissions. All metrics are risk and volume adjusted using peer reviewed, published methodologies.

Figure 2: Quality Ratings: San Francisco Complex Neurological Surgery



Consumer Experience

While insured consumers in every area of the US face significant local price and quality variability, most struggle to access the information they need to obtain better value. The provider and hospital systems are not designed to provide consumers complete and accurate in-network price estimates.[2, 3] Carrier tools are generally not promoted for their transparency features and experience low utilization.

Nonetheless, consumer surveys express demand for price and quality information and confirm the value to consumers when data are available.[4]

- 57 percent of Americans would like to know healthcare prices in advance
- 74 percent with deductibles of $3,000 or more have sought price information
- 53 percent who searched for price information saved money on care
- 82 percent who used a transparency website would use it again

Bluebook Results

As an independent transparency company, Healthcare Bluebook has been at the forefront of protecting patients by creating tools that make it easy for consumers to compare providers on cost and quality, shop for care and obtain better value. Over ten years, we have learned a great deal about healthcare shopping behavior.

> *After my doctor scheduled me for a brain MRI at a facility he always used, I checked Healthcare Bluebook for the procedure and realized that my doctor was sending me to one of the most expensive places in my area. I worked with my doctor and went to a green provider instead, saving me almost $2,000.—Bluebook Member*

We know that when consumers have access to an intuitive, easy to use solution like Bluebook they will utilize the solution to compare providers and shop for care. When consumers shop for care, they consistently make better choices on cost and quality. In our experience, consumers who shop for care are 2 to 3 times more likely to select a cost-effective provider than those who do not shop.

We also understand that when consumers with high deductibles and co-insurance utilize cost effective providers they realize significant out-of-pocket savings. Consumers can typically save an average of $1,500 on imaging and diagnostics, $2,000-$5,000 on outpatient procedures and as much as $8,000 or more on inpatient procedures.

Increasing the use of cost effective providers also has an impact on overall employer plan costs. Over a ten-year period, Bluebook clients have saved in excess of $240 million through better transparency.

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[2] James, Steve. "How Much Will Surgery Cost? Good Luck Finding Out." NBC News, 2 Nov 2013.

[3] Jegtvig, Shereen. "Hospitals will quote prices for parking, not procedures." Reuters Health, 2 Dec 2013.

[4] June 2017 report by Public Agenda, with support from the Robert Wood Johnson Foundation

Keys to Success

There are a myriad of design and other factors that contribute to a successful consumer transparency program. For the Committee's consideration, I will focus on the four most critical:

1. **Payor Independence:** Independent solution providers have driven innovation in transparency for over a decade. Independent providers are free from any conflict of interest that can arise for intermediaries between the provider network and the employer. We uniquely serve the interest of the employer and the consumer and are free to present data, utilize independent quality metrics and create benefit designs that incent utilization of high-quality, cost-effective providers.

2. **Ease of Use:** Healthcare navigation and pricing are complex. Intuitive design and actionable information are critical for making healthcare consumerism as easy as other daily transactions.

3. **Education and Engagement:** Most patients don't consume care weekly or even monthly. Many don't fully understand their benefit design or the magnitude of price differences. Successful transparency is not passive. It requires communication of timely, relevant information when patients have a need and the use of mobile apps, messaging and social media.

4. **Incentives:** Value-based rewards, like cash incentives, share a portion of savings back with patients when they make cost-effective decisions. Rewards create additional incentive for a patient to engage in consumerism, even if the patient has met their deductible or out-of-pocket maximum.

Policy Considerations

As the Committee turns its attention to policy and initiatives that can further price and quality transparency, I offer the following thoughts for the Committee's consideration:

- **Employer Data Access:** The transparency movement began in earnest a decade ago when self-insured employers, via their transparency partners, began to closely examine the price variability in historic claims. Data maintains the balance in the scale between employers and providers. Congress must ensure that self-insured employers have full access to unredacted historic claims and the right to provide their data to any partner covered by a Business Associate Agreement, without limitation.
- **Provider Consolidation:** When hospitals acquire other hospitals or outpatient facilities, local prices increase. When hospitals acquire physician practices, referral patterns reflect a proportional increase in the use of higher cost hospital-based outpatient care. A 2018 study using a national sample of commercial claims data shows that while consumption of services over the past few years is flat, and in some cases declining, employers are still experiencing high single-digit increases in healthcare expenditures.[5] The study concludes that the largest factor influencing employer medical trend is increased prices. I encourage Congress to be vigilant of the impact that consolidation has on healthcare prices and encourage policies that foster competition, an innovation that benefits consumers and plan sponsors.
- **Waiver of Out-of-Pocket Costs for HSA Eligible Plans:** Waiving out of pocket cost is an effective incentive to encourage consumers to use high-quality, cost effective providers. HSA plans currently require the full deductible to be met before the plan can cover any additional portion of out-of-pocket costs. Congress should consider easing this restriction within the context of transparency and value-based benefit design.
- **Access to CMS Data:** The past few years have seen increased access to detailed Medicare data. Improved access has spurred innovation in quality measurement initiatives, particularly in the inpatient setting and physician-specific outcomes. However, broad access to detailed encounter level data for physician office and outpatient surgeries, in both the HOPD and ASC settings, is deficient. Greater access to detailed data that allows comparison of quality outcomes for outpatient services, specifically the

[5] Health Care Cost Institute, 2016 Health Care Cost and Utilization Report

HOPD and ASC settings, would improve transparency of provider cost and quality for consumers.

Summary

Today, employers and their employees are the largest consumers of healthcare and account for $1.5 trillion of our annual US healthcare expenditure. In our experience over the past decade, when consumers shop for care they consistently make better choices on cost and quality.

We believe that policy can play a positive role to advance transparency within our US healthcare system. Employer data access, provider consolidation, waiver of out-of-pocket costs for HSA eligible plans and access to CMS data are all initiatives the Committee should consider for improving the future of healthcare for all Americans.

[SUMMARY STATEMENT OF BILL KAMPINE]

Hidden price and quality variability have a significant impact on both patient health and affordability. In the US, medical bills are the number one cause of bankruptcy, and medical mistakes (i.e. poor-quality care) are the third leading cause of death. When patients don't understand what care should cost or lack the ability to compare providers, they frequently overpay for common healthcare services by as much as 2X—10X. When patients don't have access to outcomes-based quality information, they choose poor performing doctors or facilities, increasing their risk of complications, readmission and death.

Lack of transparency also has a significant cost for employers and our broader economy. Each year employers and consumers spend approximately $1.5 trillion on healthcare. Conservatively, non-acute shoppable procedures account for on-third, or $500 billion. Based on our data, employers and consumers could save half that spend by using more cost effective in-network care—returning $250 billion to the economy.

We know that when consumers have access to easy-to-use price and quality transparency tools, they will use those tools to shop for care. In our experience, consumers who shop for care are 2X—3X more likely to select a cost-effective provider than those who do not shop.

When patients shop, both consumers and the employer save money. Consumers can save roughly $1,500 per episode on common imaging and diagnostics tests, and thousands on outpatient and inpatient care. Better consumerism also translates into overall savings for the employer. Over a ten-year period, Bluebook clients have saved in excess of $240 million.

Some critical factors for successful transparency include:

- **Payor Independence:** Independent solution providers are free of network conflicts.
- **Ease-of-use:** Intuitive design makes healthcare consumerism as easy as other daily transactions
- **Incentives:** Value-based rewards create additional incentive for a patient to engage in consumerism, even if the patient has met their deductible or out-of-pocket maximum.

As the Committee turns its attention to policy initiatives that make price and quality transparency information more widely available, we offer the following considerations:

- **Employer Data Access:** Data balances in the scale between employers and providers. Congress must ensure that self-insured employers have full access to unredacted historic claims and the right to provide their data to any partner covered by a Business Associate Agreement, without limitation.
- **Provider Consolidation:** When hospitals acquire other hospitals, outpatient facilities and physician practices, local prices increase. Congress should be vigilant of the impact that consolidation has on prices and encourage policies that foster competition, which benefits employers and consumers.
- **Waiver of Out-of-Pocket Costs for HSA Eligible Plans:** Waiving out of pocket cost is an effective incentive to encourage consumers to use high-quality, cost effective providers. HAS eligible plans currently require

the full deductible to be met before the plan can cover any additional portion of out-of-pocket costs. Congress might consider flexibility to promote value-based benefit design.

- **CMS Data:** Greater access to detailed data allowing comparison of quality outcomes for outpatient services, specifically the HOPD and ASC settings, would improve transparency for consumers.

The CHAIRMAN. Thank you, Mr. Kampine.
Ms. Giunto.

STATEMENT OF NANCY A. GIUNTO, EXECUTIVE DIRECTOR, WASHINGTON HEALTH ALLIANCE, SEATTLE, WA

Ms. GIUNTO. Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to appear as a witness today.

Since our hearing is focused on reducing healthcare costs through increased transparency and more empowered patients, let's test the current system. Let's imagine a patient I'll call Annika. Annika has just moved to a new city. She has a new job and health insurance through her employer. At the top of her to-do list is to find a primary care physician for herself, her husband, and her son. Annika's son has diabetes, and he has been closely monitored for several years. Her husband has been taking pain medication for some time as a result of a back injury, and he's having trouble getting off his medication.

Annika knows that one physician will not meet the needs of everyone in her family. She wants the best quality care at an affordable price and a great patient experience, and she needs to choose the providers that are in her health plan's network.

But where in the world does she start? Is there one place where she can find the trusted information she needs that is easily understandable in a format in which she can compare providers? The challenge for patients in our country is that the answer to this question is for the most part an emphatic and resounding no. Trusted and objective information on value, that is, cost, quality, and patient experience, is not readily available, and if parts of it exist, it's unlikely that it's all in one place.

Fortunately, there are organizations like mine, the Washington Health Alliance, that has been making headway on the issues Annika cares about. Since 2005, the Alliance is a place where stakeholders have come together to work collaboratively to transform Washington state's healthcare for the better. One hundred and eighty-five member organizations from across the state belong to empower the work of the Alliance, and we represent every stakeholder group in healthcare.

We have two core competencies. First, we're a trusted convener, convening a collective conversation on how to improve healthcare delivery and financing, and, second, our competency is data aggregation analysis for performance measurement and public reporting. Much of the data for our work comes from an All Payer Claims Database that is voluntary in our state. We have 500,000 lives that are covered by ERISA in our database on a voluntary basis.

We know that data alone does not change behavior. Transforming data to action requires stakeholder involvement and commitment and accountability. Senator Murray in her opening com-

ments mentioned a report that we recently issued called First, Do No Harm, where she mentioned the data across 47 clinical areas. To begin with, we identified $282 million worth of savings. I'd like to tell you how we're putting that to work in the State of Washington.

The Boeing Company is using that work to identify unnecessary services in their Accountable Care Organizations. We're also working on an initiative called Drop the Pre-Op, in which we're seeking physician engagement to eliminate routine pre-operative lab studies and other imaging tests on healthy people who are having a low-risk procedure. We estimate that through this work, we can conservatively save unnecessary care of about $92 million a year in our state. Fortunately, the Alliance is not alone in its efforts. Regional health improvement collaboratives, or RHICs, including Alliance, are hard at work in 32 states, including 14 states represented by Senators on this Committee.

I would say that, ideally, health transparency must include all aspects of value, cost, quality, and patient experience, not just cost. I agree with my fellow panelist. Cost transparency is very important, but it's not enough. We must be able to look at cost and understand what we get for it. Do the services I am paying for improve my health, and are they clinically appropriate? Measuring this is very challenging, and reporting in a comprehensive way is even more challenging, and I think we would all agree we have much work to do in our country.

Empowering patients to choose high-value care is very challenging as well. Here are four ways to equip patients to be better—to make better decisions about their healthcare.

First, significantly expand efforts to teach consumers that cost and quality of healthcare are highly variable, that they are measurable. They should use that information to become more informed consumers of care. Secondly, focus on prioritizing health literacy. Eliminate medical jargon. Don't assume consumers or employers understand our very complex system.

Third, deliver objective, easy to understand information that is available on demand to consumers at the point of care or when they are seeking care. And, finally, enlist physicians and other clinicians to promote transparency. In a recent study that we did, we found that there were only 23 percent of respondents answering yes to a survey about whether office staff or physicians could help them identify the cost of care prior to a procedure or a prescription.

Let me thank you for the opportunity to testify today.

Thank you.

[The prepared statement of Ms. Giunto follows:]

PREPARED STATEMENT OF NANCY A. GIUNTO

Committee Chairman Alexander, Ranking Member Murray and Members of the Health, Education and Pensions Committee, I very much appreciate the opportunity to testify on the topic, "Reducing Health Care Costs: Examining How Transparency Can Lower Spending and Empower Patients."

My organization, the Washington Health Alliance, or the Alliance for short, is a place where for the last thirteen years, stakeholders have come together to work collaboratively to transform Washington State's health care system for the better. The Alliance brings together organizations that share a common commitment to drive change in our health care system by offering a forum for critical conversation and aligned efforts by key stakeholders: purchasers (i.e. employers and union trusts),

providers, health plans, consumers and other health care partners. 185 member organizations from across our state belong to and power the work of the Washington Health Alliance.

The Alliance Board of Directors is comprised of 24 very senior health care and business leaders from across our state (Appendix A). This level of leadership is essential to leverage initiatives and to implement them.

The Washington Health Alliance has two core competencies. First, we are a trusted convener for stakeholders, promoting a collective conversation to transform health care delivery and financing. Our second core competency is data aggregation for the purpose of performance measurement and public reporting.

Much of the data for our work on public reporting and measurement comes from a voluntary All Payer Claims Database—or APCD—that the Washington Health Alliance started in 2007 and continues to maintain today. The Alliance's APCD is supported by 35 data submitters, including commercial and Medicaid insurers in our state plus self-funded ERISA employers. As you are aware, ERISA preempts any state law requiring self-insured employers to submit health care claims data to a state-mandated APCD. Our voluntary APCD contains 550,000 ERISA lives and information on a total of 4 million Washingtonians.

Transforming Data to Action Requires Multi-Stakeholder Engagement and a Commitment to Value-Based Purchasing

Accurate data that is transparent to all key stakeholders is essential, but insufficient to drive improvement and better value in health care. Data alone does not change behavior; it also takes trust, dialogue and communication from respected leaders. All stakeholders must be actively engaged in the effort to prompt action as shown on the diagram on page 3. This starts by turning data into understandable information, which requires translating technical information for multiple audiences through the use of compelling stories. Information that is well understood by all key parties can then be used to promote engagement, target specific areas and tools for action, and ultimately produce outcomes such as better health, lower cost and less waste for patients.

Engaging each stakeholder group requires answering two key questions, "how do we hold one another accountable for our collective commitments?" and, "what's in it for me?"

Health care is an industry characterized by many silos with too few aligned financial incentives. There is not enough interaction or alignment between those paying for care (purchasers), those receiving care, and those providing the care. Each stakeholder group must be invested and have a collective commitment to move transparent data to action to improve health care for individuals in our communities.

Managing stakeholder accountability requires a careful balance—creating a vision for collaboration while also bringing tension to bear so all organizations stay at the table to accomplish goals that support patients. It is extremely challenging (and some would say impossible) for an individual patient to effectively navigate the health care system alone. They need the synergy and mutual accountability

amongst and between all health care stakeholders to create a system of care that works for their benefit.

The balancing act to drive mutual accountability among diverse stakeholders demands effective relationships, candor, trust and tenacity. It requires a clear understanding and an ability to demonstrate how involvement in the collective benefits each individual stakeholder group and ultimately benefits the patient. And finally, it requires a neutral, objective and third-party facilitator that has a "table" big enough to include all and a reputation that engenders trust when discussions are strained. This is the role of the Washington Health Alliance and other organizations like us.

Here are a few concrete examples of the critical role each key stakeholder group needs to play in order to achieve the desired outcomes of improved health, reduced cost and less waste for patients.

Providers: A frequent axiom in health care (and other industries) is that you cannot improve what you don't measure. To date, health care improvement has centered primarily on measuring quality, patient experience, and to a lesser extent, cost. Providers (i.e. physicians and other clinicians, hospitals, etc.) are at the epicenter of much of these efforts and are affected by the results of measurement through both incentives and penalties. Since they have tremendous impact on results, their buy-in is instrumental to progress. In other words, to create an action-focused data base, providers who are reported on must have a genuine and active role in creating the methods used to produce results. For example, providers must agree to an attribution policy so patients they have cared for are correctly assigned to them. In addition, providers must have the opportunity to validate results and to have a say in the way evidence-based clinical measures are included in a report. Action will only happen if providers are an integral part of the process and when they generally support the evidence-based conclusions and rankings that are drawn. By participating in this process, they are ensuring that the information the public sees is a reasonably accurate reflection of the quality of care they provide. We know from experience that they don't always like what they see, but they will accept the results and move forward to drive improvement IF they have been a part of the process. We are so fortunate in Washington to have providers who are willing to stand up and be counted, to be publicly ranked on the care that they deliver, and to look for opportunities to learn from the results and improve practice.

Purchasers: Employers and union trusts can have tremendous leverage in driving better value in health care for their employees, particularly if they use their buying power and collaborate with other purchasers on ways to buy health benefits for value together. Purchasers write big checks for health care and they should expect more of providers, pushing them to adopt best practice protocols and prompting them to improve performance if they are below the state average or the results of competitors. Purchasers should press health plans to develop products that include measures of value and, once developed, they should actually buy them. In the end, the purchaser benefits by having more productive, healthier employees and lower health care expenses overall.

The Washington Health Care Authority is the largest health care purchaser in our state, covering state employees and the Medicaid insured population, and accounting for 25 percent of the total spend. We benefit tremendously from the example they set by leading the way in purchasing for value through accountable care programs and procedure-based bundled payments (knee and hip replacements, spine surgery) that are already in place, and through rural health care payment initiatives under development. The Boeing Company, also a very large purchaser in our state, is leading by example as well, by also purchasing for value through accountable care programs and implementing innovative tools to encourage consumer engagement in smart health care choices.

Insurers: Health plan leaders need to continue to advocate for value-based purchasing through active engagement with purchasers and through physician contracting that embeds elements of value directly in payment terms. Transparency of information is dependent on the commitment of health plan leaders to engage and trust others with their data. Washington health plan leaders have trusted the Washington Health Alliance with claims-level quality data since 2007. In addition, most commercial plans have also entrusted us with "billed, paid, and allowed" charge information at the claims

line level on a voluntary basis beginning in 2017. These leaders understand that transparency is paramount to building trust with purchasers and to aligning efforts to transform health care for the patients we all serve.

Specific examples in Washington State of moving data to action

The Washington Health Alliance produces several reports each year that address the persisting obstacles to the best care and patient experience. Our members and stakeholders use these reports to make impactful changes, as described below in several examples.

- *King County,* the largest county in the State of Washington and a founding member of the Washington Health Alliance, employs 14,000 individuals in professional, technical and service positions. County leaders regularly invite Alliance staff to their joint labor management insurance committee to engage in conversations about the Community Checkup and other Alliance reports about the quality of health care in Washington State. King County is actively designing health benefit plans and employee engagement programs that help guide employees in making thoughtful choices about health and healthcare options. They utilize Alliance materials extensively in the creation of these employee engagement programs.
- *SEIU 775 Benefits Group* provides health care benefits for approximately 18,000 home health caregivers. They are addressing the issue of behavioral health risks in the caregivers they support by partnering with Kaiser Permanente Washington (a primary insurer for the SEIU 775 members) as well as other community organizations to offer a range of behavioral health services including: a mobile coaching app, video chat services to Kaiser Permanente members needing behavioral health services, depression and anxiety screening, and in-person and on-line mindfulness classes. This effort grew, in part, from conversations at the Alliance's Purchaser Affinity Group about ways purchasers can engage more deeply in employee behavioral health issues.
- The Washington Health Alliance's "First, Do No Harm" report, released in February 2018, received national attention for its ground-breaking work on overuse and waste in health care.[1] In this report, we identified an estimated $282 million in unnecessary services in one year in our state exploring only 47 such services initially. We used the Health Waste Calculator developed by Milliman to perform this analysis on 2.4 million commercially-insured lives in our voluntary APCD.

The Boeing Company, a strong supporter of the Alliance and a data submitter, retained us to use the health waste calculator to analyze their data and identify unnecessary services in their Accountable Care Organizations. Activities are now underway to improve processes of care and eliminate waste based on our work together.

The Alliance is taking further action with this report by working with our state-wide Choosing Wisely Task Force, comprised of physician leaders as well as representatives from the Washington State Hospital Association and the Washington State Medical Association. This group is working on an initiative called "Drop the Pre-op!" (Appendix B) in which we are seeking physician engagement to eliminate routine preoperative lab studies, pulmonary function tests, chest X-rays and EKGs on healthy people before low-risk surgical procedures. We conservatively estimate the cost of this unnecessary care to be approximately $92 million a year.

- The *Everett Clinic,* a nationally known and progressive delivery system located north of Seattle, used the Alliance's Hospital Value Report to have a conversation with its major referring hospital to understand why the hospital was performing below average in some areas and how they could work collaboratively to improve.[2] The Hospital Value report looks at the three key elements of value: quality, patient experience and price, and combines these factors to view performance variation of hospitals in Washington. Importantly, the results refute the common belief that high-

[1] First Do No Harm: Calculating Health Care Waste in Washington State. Washington Health Alliance, February 2018

[2] Hospital Value in Washington State. May, 2018

er prices always correlate with better care and improved outcomes for patients.

- The Alliance was instrumental in leading the work in Washington to develop a statewide Common Measure Set on Healthcare Quality and Cost, with the starter measure set agreed upon in late 2014.[3] The Washington Health Alliance has reported results on its Community Checkup website for all measures and all units of analysis since 2015.[4] To date, Washington is one of only a handful of states nationwide to accomplish agreement on a common measure set and we receive inquiries on a regular basis about our strategies and processes. Numerous purchasers and health plans use a subset of these measures as the basis for monitoring and paying for health care quality in their contracts. Providers incorporate measures and results into quality improvement efforts.

Fortunately, the Alliance is not alone in its efforts as a regional health improvement collaborative (RHIC). The Network for Regional Health Improvement (NRHI) represents more than 30 RHICs and state-affiliated partners (including the Washington Health Alliance), all working toward the common goals of better health, better care, and lower costs. NRHI members are hard at work in 32 states, including 14 states represented by Senators on this Committee. Although each NRHI member does things a little differently due to differences in demographics, market forces, skills and expertise, we are all deeply committed to the fact that the health care system is broken, that a multi-stakeholder approach is essential to affecting change, and that solutions must be data-driven.

Examples of moving data to action from other states and NRHI members

- Under *NRHI's leadership,* five RHICs from Colorado, Maine, Missouri, Minnesota and Oregon standardized measurement and reporting of the total cost of care to understand relative differences in the underlying drivers of cost. Bringing states with higher than average costs down to the average of the participating states could potentially save over $1 billion annually. This report is being used by legislators, state agencies, employers, providers and payers to develop strategies to reduce overall costs.
- The *Kentuckiana Health Collaborative (KHC)* worked on an initiative to improve health while minimizing administrative burden. The Kentucky Core Healthcare Measures Set (KCHMS) was developed by over 70 experts from 40 organizations to align payers and purchasers around a shared set of priority measures that drive improved health, quality of care and value, and reduce administrative complexity and waste. Kentucky's new set contains 32 measures, less than half of the 89 currently incented measures.
- *Maryland Health Care Commission (MHCC)* created a "Wear the Cost" campaign. A campaign website was launched to empower consumers to get involved in their own health care, with numerous ways to take action. The campaign provides cost and quality information for consumers and providers to raise awareness of variation among hospitals statewide, helping patients make high-value choices to reduce overall costs. Additionally, consumers can sign an appeal asking doctors, hospitals, and insurance companies to work together to make costs public and provide high-quality care. Consumers also can order a Wear the Cost t-shirt to build awareness in their community.
- *Integrated Healthcare Association (IHA)* created the *California Regional Health Care Cost & Quality Atlas.* This atlas is a state-wide publicly available improvement measurement tool that reports on over 29 million insured Californians providing a roadmap for reducing cost and quality variation. Regional and insurance product line information shows where quality and cost are trending in the right direction and where there is room for more improvement in specific areas within the state.
- *The Health Collaborative in Cincinnati, Ohio* works with over 560 physician's groups across the State of Ohio to aggregate payer data and measure performance in one of the largest payment demonstration models in

[3] Common Measure Set on Healthcare Quality and Cost. Health Care Authority Performance Measures Coordinating Committee, 2018

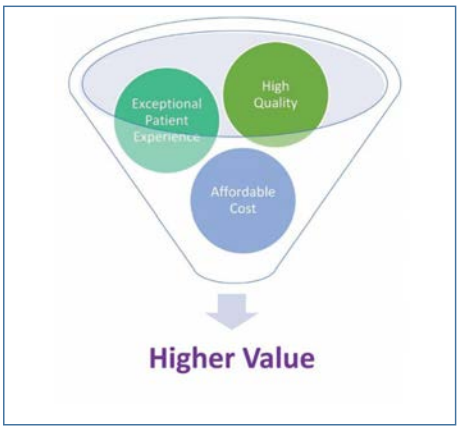
[4] Washington Health Alliance. "Community Checkup." *wahealthalliance.org/alliance-reports-websites/community-checkup/*

the country. The outcome of this effort has created significant data-driven cost and quality improvements, in addition to better health outcomes for the patient populations these providers serve—including a 33 percent reduction in hospital visits, an 11 percent reduction in emergency department visits, and $112M in lowered cost.

- One RHIC leading the way in reporting on value is *HealthInsight Oregon.* This organization creates multi-payer, comprehensive reports at the medical clinic level including price, resource use, utilization and quality data for patients attributed to the clinic across inpatient, outpatient, and professional settings. These reports allow providers to understand how they are performing in categories such as medication management, avoidable emergency department visits, and imaging services in comparison to their peers, and identify areas for improvement. In 2018, Oregon will be publicly releasing cost data paired with quality data, allowing consumers to make informed choices about where to seek high-value primary care.

Transparency Must Include All Aspects of Value—Cost, Quality and Patient Experience- Not Just Cost Alone

The Alliance believes strongly in transparency and is working diligently to offer trustworthy and credible reporting of progress on all measures of health care value (cost, quality and patient experience) as shown on the next page.



Measuring health care **value** is challenging. Those who are most engaged in this work across the country would acknowledge that critical capabilities are in different stages of development. For example, more states/regions are aggregating and using health insurance claims data to measure very important health care processes, as we do at the Washington Health Alliance; however, the infrastructure to access hundreds of millions of medical records and/or patient surveys to effectively measure clinician and patient-reported outcomes is in a more nascent stage. Similarly, statewide measurement of patient experience with physicians in a standardized manner (i.e., using a nationally-vetted survey instrument) to support transparency/public reporting is only available in Washington State and a small handful of other states. [5] And price transparency—sharing accurate detail on pricing variation (including total cost and consumer out-of-pocket liability) for treatments, procedures and medications—is largely unavailable in most states apart from the "cost calculators" offered by several health plans, some of which are quite limited. Moreover, a majority

[5] Patient experience is different than patient satisfaction. Patient experience asks patients whether or not, or how often, certain behaviors occur during the course of their care. For example, how well does my provider communicate with me? Or how well do providers work together to coordinate my care? Conversely, patient satisfaction is more of a business loyalty measure and addresses how patients feel about their provider, generally acknowledged to be a highly subjective measure. Higher patient experience correlates with better health care outcomes, whereas there is little or no correlation between patient satisfaction and outcomes.

of patients are often unaware of the existence of these reports and tools, or may be unclear on how to interpret the available information.

Ideally, all elements of value would be reported on together in a single, comprehensive and understandable way, i.e., a summary of value. The Alliance Board of Directors encourages us to report on all aspects of value and we are having some modest initial success, such as in the Hospital Value Report mentioned earlier. That said, summarizing value into a single score is challenging for multiple reasons:

- First it is technically challenging to create a summary of value across thousands of provider organizations within any given region or state. It involves aggregating and integrating data from multiple and disparate data sources, like insurance claims, electronic medical records and patient-reported outcome surveys.
- Second, we know from our work in measuring health care quality that provider organizations may excel in some areas of care, while demonstrating significant deficiencies in other areas of care. It is generally true that most health care provider organizations are not good at everything, even including those with national reputations—all have room for improvement.
- Third, this type of reporting is very difficult to achieve because the importance given to each element of value depends to some degree on the user. In other words, it is preference-based and preferences are not static. For example, one person may place more value on how well a provider treats a disease like diabetes than on the cost of that care, perhaps because they have excellent health care coverage through their employer with minimal out-of-pocket requirements. Conversely, another person may be a generally healthy patient with very little current need for health care but may be in a financially precarious situation (uninsured or underinsured); this person will likely place greater value on the cost part of the equation. Moreover, preferences can change quickly with an individual's circumstances, such as diagnosis of an illness or change in employment status. Thus, the health care ecosystem does not lend itself to simple star rating systems or other common rating tools. The complexity and variability of health care resists simplistic methods for aggregating variables into a single "Amazon-like" rating system because it may not reflect the user's dynamic preferences.

Purchasers in particular are interested in linking each of the elements of value together when they design benefit plans for employees. Although it is true that most purchasers have focused their health benefit strategies more heavily on managing health care costs, they also care that employees have a high quality, patient-centered experience at a fair price. In today's tight labor market, this is more salient than ever; productivity and recruitment/retention are high priorities. Purchasers are seeking value. "Cost calculators" are not enough. Ideally, future reporting will include and combine all aspects of value—cost, quality and patient experience. We must be able to look at health care cost and understand what we get for it. Health care decision-makers deserve answers to basic questions: Does the expense improve the outcome of care? Is the expense for services that are clinically necessary and appropriate or, is it simply a wasteful, overuse of care? It is not all about the lowest price per service. Instead, it is about a favorable total cost of care for an episode of care (such as a maternity stay, total hip replacement, or the care of a patient with diabetes over the course of a year) that has positive health outcomes and provides a good patient experience.

How to Empower Patients to Choose High-Value Care

Empowering patients is a tremendous challenge in health care, and yet absolutely essential. Health care-related topics (diseases, medications, procedures) are complicated and the language typically used to describe them is not easy to understanding by those not trained in health care professions. Patients are often daunted by the complexity of the system we have created and perpetuate. Many of the consumer-facing tools that have been developed, like health plan cost calculators and price comparison tools available through APCDs, have not had enough uptake.

There are essentially four ways to reach consumers: 1) through their physician and health care team; 2) through their employer; 3) through their health plan or 4) through direct-to-consumer mass media (e.g. advertising). Evidence has shown that the general public does not fully understand basic information about health care and health insurance, and many employers view it as their responsibility to

design benefit packages that incentivize use of higher-value providers. Others are educating and incentivizing their employees to engage more directly in care decisions by investing in tools that combine cost and quality information for a specific benefit plan or by offering concierge navigators to assist individual patients to move through the health care system for their specific needs.

Education and navigation resources are a critical unmet need, especially for consumers who may not have assistance from their employers. Dr. Jamie S. King's testimony to the Subcommittee on Oversight and Investigations to the Committee on Energy and Commerce in the U.S. House of Representatives does an excellent job of discussing the challenges and the empirical evidence regarding consumer engagement in various tools.[6] Research shows us that it is very difficult for a patient to make choices, particularly when faced with complex research sets[7]. We also know that the way health care information is presented to a consumer matters. One study from the journal Health Services Research suggests that using actual dollar amounts for cost, and evaluative symbols (like better, average and below average), aid decision making.[8]

Regardless of the communication channel, there are universal considerations that would enhance consumer engagement. We need to deploy all of these to further empower health care consumers to make well-informed decisions about their health care.

1. Teach consumers that the quality of health care is measurable and highly variable and that they can be better consumers of care

All consumers need to learn that health care value is highly variable and that they can be better consumers of care. While it may be unrealistic to expect the average person to become an expert on health care value, simple tools and resources can illustrate the variation, helping a person make more informed choices about their care, especially at key moments, e.g., selecting an insurance plan, finding a primary care provider, selecting a hospital for an elective procedure, or managing a chronic illness.

The Alliance and the Washington State Health Care Authority partnered together to create the Savvy Shopper series to support this educational need (Appendices C- G). There are three personas around which the Savvy Shopper series is built: Olivia, who is shopping for quality; Michael, who is interested in his patient experience with a provider; and Ann, who is interested in using health care dollars wisely. Choices faced by each of these consumers are portrayed in graphical format for ease of comprehension. The infographics prompt consumers to take simple action steps to address their specific situation and make informed choices. A summary infographic educates consumers on what actions to take during open enrollment, and before, during and after a visit.

2. Focus on health literacy

Considerable literature has illuminated the epidemic of low health literacy, defined as the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[9] To counter this formidable challenge, health systems and clinicians are advised to communicate (verbally and in writing) in plain language, eliminate medical jargon and use tools such as "teach back" to ensure understanding. Unfortunately, because they are steeped in the language of health care, clinicians and insurers often overlook the fact that most consumers and employers don't understand health conditions and what is required to manage them, much less the complexity of the health care system. Adding to this complexity, but no less important, is that communication must be tailored based on important demographics such as race and ethnicity, language and cultural considerations.

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[6] United States. Cong. House. Committee on Oversight and Investigation. Hearing on Examining State Efforts to Improve Transparency of Health Costs for Consumers. July 17, 2018. 115th Cong. 2nd Sess. Washington: GPO, 2018. Statement of Jamie King, PhD, Professor, UC Hastings College of Law.

[7] Schlesinger, M., D. E. Kanouse, S. C. Martino, D. Shaller, and L. Rybowski. 2014. "Complexity, Public Reporting, and Choice of Doctors: A Look Inside the Blackest Box of Consumer Behavior." Medical Care Research and Review: MCRR 71 (5 Suppl): 38S–64S.

[8] Greene, J. and R. M. Sacks. "Presenting Cost and Efficiency Measures that Support Consumers to Make High-Value Health Care Choices." Health Services Research: © Health Research and Educational Trust, DOI: 10.1111/1475–6773.12839. RESEARCH ARTICLE

[9] *https://health.gov/communication/literacy/quickguide/factsbasic.htm*

Purchaser members of the Alliance Board often remind us that health care is not their core business—they make airplanes or coffee, or run large union trusts. They encourage us to communicate directly and simply. The Consumer Education Committee of the Washington Health Alliance coaches us in the same way. A great example of the notion of "don't assume anything" is the advice we received from this committee as we engaged them in developing an infographic for consumers on the opioid epidemic. Their strong advice was that many people who are taking Percocet or Hydrocodone don't equate these brand-named drugs with the fact that they are taking an opioid. The infographic we developed (Appendix H) highlights frequently prescribed opioids.

In general, simple one-page infographics are a very effective way to communicate the substance of an idea. Appendices I and J contain examples of effective infographics we have developed over the years, focused on consumers.

3. Deliver meaningful information, ideally at the time that care is being sought or delivered

Health care encounters are typically brief and episodic. In the absence of a chronic or acute need, most individuals do not spend the majority of their waking hours thinking about health care or making choices about finding high quality care. Rather, consumers want information as close to the time of care as possible and they need it in an easily digestible way from a trusted source. Education about health care (e.g. information about health insurance and navigating the health system) should be embedded into primary and secondary education. This area is also ripe for entrepreneurs to develop and continue to refine mobile applications that are accessible by smart phone or other communications channels at the point of service and/or the point of need.

The Alliance's Community Checkup website is a resource for unbiased, trustworthy data and analysis of the quality of health care in Washington State.[10] It incorporates Tableau functionality to allow a user to compare results across hospitals, medical groups, clinics, health plans, Accountable Communities of Health, counties and the state in an interactive and intuitive way. Consumers are also drawn to our "Own Your Health" website to become better educated on the complex nuances of health care, through articles and other resources, to learn how to become better shoppers of health care value.[11] Additionally, the Alliance partners with our members to deliver customized content through the Own Your Health website, reinforcing our earlier point that employers are a vital channel for reaching individuals with credible information about health and health care decision-making.

4. Enlist physicians and other clinicians to help promote transparency

Consumers, who have a trusted relationship with their physician and other care givers, depend on them for advice and guidance. As the clinicians on the HELP Committee know, a strong patient-physician relationship and patient engagement are essential to how well a patient will follow through on medical advice. Following through on medical advice, in turn, leads to better health outcomes.

This means we must involve health care teams directly in the work of consumer empowerment and continue to enlist their advocacy for greater transparency. In particular, we need to find ways to make it easy for health care teams to talk about the cost of care they are delivering and/or be able to direct patients to specific resources that offer accurate information to support decisions. Discussion of money "inside the exam room" has always been considered off-limits or distasteful. But we must get past this cultural barrier and utilize the trusted relationship between provider and patient to educate patients about health care costs and to help them avoid financial harm.

"Your Voice Matters," our patient experience survey sent to 250,000 people across the state, is the only report of its kind to produce comparable, publicly available patient experience results for primary care providers in

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[10] Washington Health Alliance. "Community Checkup." *wahealthalliance.org/alliance-reports-websites/community-checkup/*

[11] Washington Health Alliance. "Own Your Health." *wahealthalliance.org/alliance-reports-websites/own-your-health/wahealthalliance.org/alliance-reports-websites/community-checkup/*

Washington State.[12] Patients who have seen their doctor in the past year are asked to report their experiences with their health care provider and the provider's office staff. In one section, patients were asked if before receiving a recommended test, procedure or medication, the provider or office staff helped them find out how much it would cost. Only 23 percent of the respondents answered yes to this question. The majority of patients are not getting information on the cost of their health care before they receive services. Lack of cost information may result in large, unexpected out-of-pocket costs, a phenomenon well documented in the literature.

What Actions Should Congress Take?

1. Create incentives across stakeholder groups to align on transparency initiatives and purchasing for value.

Unfortunately, most transparency efforts in health care are currently not aligned and can greatly vary across stakeholders and different payers. This creates confusion for patients who want to be able to evaluate costs and qualities across different entities. Congress should address this issue in a collaborative way, working to align different efforts. This requires the involvement of multiple stakeholders and coordination across public and private programs; otherwise, patients may be overwhelmed by competing information or lack key data points they need to appropriately compare different choices. Mandates that address only one sector or create greater fragmentation due to disparate transparency requirements will likely complicate the problem.

As a predominant purchaser of health care in the United States, federal health insurance programs have a duty to remain committed to advancing smarter approaches to health care payment and delivery. CMS has shown some success in shifting Medicare's delivery system into value-based care. The agency has met its initial goal of tying at least 30 percent of Medicare payments to quality performance or value-based arrangements by 2016 and remains on track to achieve 50 percent by 2018. By propelling transformative changes in the way federal programs pay for health care, CMS can improve care quality and better control care costs in its own programs, while also sending a strong signal to participants in the private health insurance market to do the same.

To continue to improve, CMS should draw on lessons from payment innovations supported by regional healthcare improvement collaboratives who play an essential role in working to implement transparency tools that are supported across a broad and diverse group of healthcare stakeholders.

2. Support Federal agency initiatives that make health care value data more transparent and focus on value.

The announcement by CMS Administrator Seema Verma to require hospitals to post prices on the Internet by January 1, 2019 is a step in the right direction, and is a good example of the government's role in pushing for price transparency. We encourage promotion of agency initiatives that tie cost, quality and patient experience as tightly together as possible.

The Qualified Entity Program put in place to make Medicare data more transparent should be modified to make the process to access data less burdensome, while still having a very tight data security and data use system in place. In addition, use cases should be loosened to allow more public reporting. Current requirements make the data very expensive to obtain. Public reporting restrictions do not maximize transparency given who can obtain results and how data sets must be combined in reports.

3. Strengthen the role of regional health improvement collaboratives (RHICs) in developing data sets and communicating health information

Rather than starting from scratch, Congress should leverage existing networks that already have the trust and support of local stakeholders and who are already working to make care improvements. RHICs play an important role in working to implement transparency tools that are supported across a broad and diverse group of healthcare stakeholders.

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[12] Your Voice Matters: Patient Experience with Primary Care Providers in Washington State. Washington Health Alliance. February, 2018

Congress should highlight and support the work of RHICs to bring greater awareness to these activities and help the work of RHICs expand those efforts that are working to improve quality and reduce costs for the benefit of patients.

Closing

I would like to thank the Members of the Health Education Labor and Pension Committee for holding this important hearing on patient empowerment and health data transparency. Thank you also for devoting time to four other important health care topics in the preceding three hearings and the fifth hearing to follow. I applaud your efforts to address the unaffordability of health care in a bipartisan way and urge you to be bold as you make decisions to benefit the citizens of our country.

Appendix A

Appendix A

WASHINGTON HEALTH ALLIANCE

Washington Health Alliance Board of Directors, 2018

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Al Fisk, MD - Chief Medical Officer, The Everett Clinic

Sarah Greene - Executive Director, Health Care Systems Research Network

Christopher Kodama, MD - President, MultiCare Connected Care, LLC

Tim Lieb – President, Regence BlueShield

Charlene Lind - Account Executive/Compliance Manager, Northwest Administrators

Appendix A

Pamela MacEwan - Chief Executive Officer, Washington Health Benefits Exchange

Greg Marchand - Director, Benefits and Integration, The Boeing Company

Larry McNutt - (Past Chair) Senior Vice President Corporate Administration & Pension, Northwest Administrators, Inc.

Steve Mullin - President, Washington Roundtable

Peter Rutherford, MD - Chief Executive Officer, Confluence Health

Paul Sherman, MD - Chief Operating Officer and Medical Director of Care Delivery, Kaiser Permanente Washington

Ron Sims - Former King County Executive Director and Deputy Director of HUD

Claire Verity - Chief Executive Officer, Pacific Northwest States, E & I Local Markets, UnitedHealthcare Community Plan

Caroline Whalen - County Administrative Officer and Director for the King County Department of Executive Services, King County

Carol Wilmes - Director of Member Pooling Programs, the Association of Washington Cities

Appendix B

DROP THE PRE-OP!

Physicians Agree: All patients need pre-op EVALUATION, but a low-risk patient having a low-risk procedure does not need pre-op TESTING.

Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state[1], reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over $92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are not recommended because they are unlikely to provide useful, actionable information.

Choosing Wisely® Recommendations

> Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal."
>
> **—American Society of Anesthesiologists**

> Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms."
>
> **—American Academy of Family Physicians**

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient's health or a procedure's risk.
- A desire to be "thorough" and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

[1] First, Do No Harm. https://www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient's financial burden.
- Reduces waiting for test results and anxiety from false-positive results.
- Reduces unnecessary delay before procedure.

For physicians:

- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won't impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

Choosing Wisely — An initiative of the ABIM Foundation

WASHINGTON STATE TASK FORCE

WA Health Alliance · WSMA Washington State Medical Association · WSHA Washington State Hospital Association

For more information and resources, visit:
wsma.org/Choosing-Wisely

Appendix B

Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

	Physical Status of Patient Undergoing Low-Risk* Procedure (determined based on history and evaluation)		
	LOWER RISK PATIENTS		HIGHER RISK PATIENTS
Pre-op Test	**ASA I** A normal healthy patient	**ASA II** A patient with mild stable systemic disease	**ASA III-V** A patient with severe systemic disease or a patient who is not expected to survive without the operation
Chest X-ray	DO NOT ROUTINELY ORDER		DO NOT ROUTINELY ORDER
Coagulation studies	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Complete metabolic panel	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
EKG or echocardiography	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Full blood count test	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Pulmonary function test	DO NOT ROUTINELY ORDER		CONSIDER ORDERING PER GUIDELINES
Urinalysis	DO NOT ROUTINELY ORDER *(unless urologic procedure)*		CONSIDER ORDERING PER GUIDELINES

* **Examples of Low-Risk Procedures:** arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

Recommended Actions

Physicians, Hospitals and Other Health Care Organizations

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: "This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure."
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs; make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.

Payers

- Review medical policies and prior-authorization requirements to ensure they clearly do not require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.

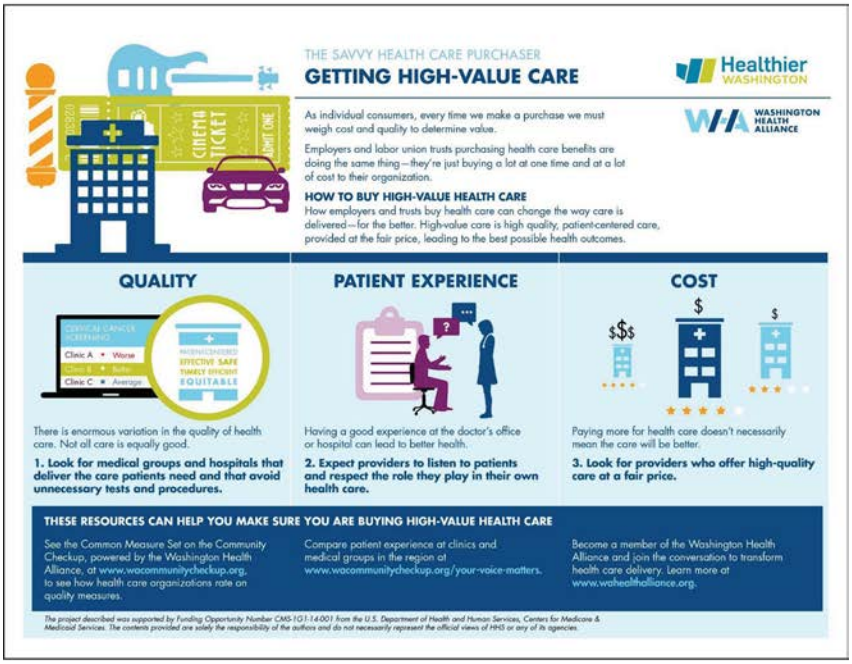
Choosing Wisely® — An initiative of the ABIM Foundation

WASHINGTON STATE TASK FORCE

WA Washington Health Alliance | WSMA Washington State Medical Association | UW Washington State Hospital Association

For more information and resources, visit:
wsma.org/Choosing-Wisely

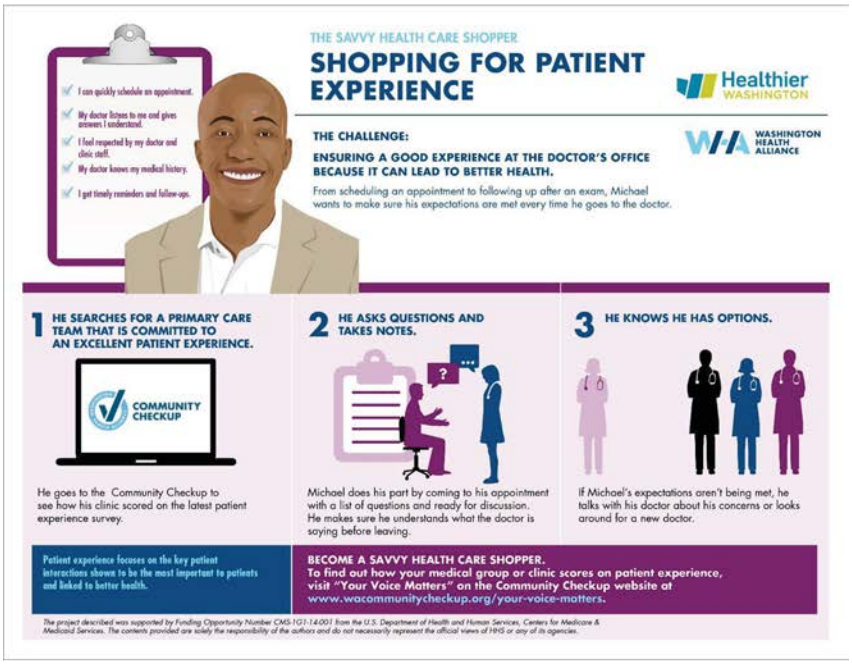
Appendix C


THE SAVVY HEALTH CARE PURCHASER
GETTING HIGH-VALUE CARE
Healthier WASHINGTON
WHA WASHINGTON HEALTH ALLIANCE
As individual consumers, every time we make a purchase we must weigh cost and quality to determine value.
Employers and labor union trusts purchasing health care benefits are doing the same thing -- they're just buying a lot at one time and at a lot of cost to their organization.
HOW TO BUY HIGH-VALUE HEALTH CARE
How employers and trusts buy health care can change the way care is delivered -- for the better. High-value care is high quality, patient-centered care, provided at the fair price, leading to the best possible health outcomes.
CINEMA TICKET
QUALITY
Clinic A Worse
Clinic C Average
EFFECTIVE SAFE TIMELY EFFICIENT EQUITABLE
There is enormous variation in the quality of health care. Not all care is equally good.
1. Look for medical groups and hospitals that deliver the care patients need and that avoid unnecessary tests and procedures.
PATIENT EXPERIENCE
Having a good experience at the doctor's office or hospital can lead to better health.
2. Expect providers to listen to patients and respect the role they play in their own health care.
COST
$$$
$
$
Paying more for health care doesn't necessarily mean the care will be better.
3. Look for providers who offer high-quality care at a fair price.
THESE RESOURCES CAN HELP YOU MAKE SURE YOU ARE BUYING HIGH-VALUE HEALTH CARE
See the Common Measure Set on the Community Checkup, powered by the Washington Health Alliance, at www.wacommunitycheckup.org, to see how health care organizations rate on quality measures.
Compare patient experience at clinics and medical groups in the region at www.wacommunitycheckup.org/your-voice-matters.
Become a member of the Washington Health Alliance and join the conversation to transform health care delivery. Learn more at www.wahealthalliance.org.
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Appendix D


THE SAVVY HEALTH CARE SHOPPER
SHOPPING FOR QUALITY
Healthier WASHINGTON
WHA WASHINGTON HEALTH ALLIANCE
THE CHALLENGE:
THERE IS ENORMOUS VARIATION WHEN IT COMES TO THE QUALITY OF HEALTH CARE. NOT ALL CARE IS EQUALLY GOOD.
Olivia just enrolled in her new health plan and is looking for a clinic that provides high quality care.
She wants to find a primary care provider now to help her stay healthy and care for her if things change.
1 SHE COMPARES CARE.
PREVENTION/ SCREENING
CHRONIC DISEASE CARE
Clinic A ▼ Worse ▼ Worse
Clinic B ● Better ■ Average
Clinic C ■ Average ● Better
Olivia "shops" for a clinic on the Community Checkup website to find out how providers in her network rate on quality measures.
2 SHE MAKES AN INFORMED CHOICE.
What are your hours?
Tell me about your providers.
Do you accept my insurance?
By comparing scores, Olivia finds high scoring clinics in her neighborhood and contacts them to see if they'd be a good fit.
3 SHE MAKES SURE SHE GETS THE RIGHT AMOUNT OF CARE.
$$$
NOT TOO MUCH
Unnecessary care costs money and can be harmful.
It's important to find the right provider and be engaged in your care.
NOT TOO LITTLE
Patients with chronic conditions do not always get the recommended care.
Many people don't get regular screenings, which can catch disease earlier.
BECOME A SAVVY HEALTH CARE SHOPPER.
Visit the Community Checkup at www.wacommunitycheckup.org and find out how you can get the quality care you deserve.
The project described was supported by Funding Opportunity Number CMS-TG1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Appendix E


I can quickly schedule an appointment.
My doctor listens to me and gives answers I understand.
I feel respected by my doctor and clinic staff.
My doctor knows my medical history.
I get timely reminders and follow-ups.
THE SAVVY HEALTH CARE SHOPPER
SHOPPING FOR PATIENT EXPERIENCE
Healthier WASHINGTON
WASHINGTON HEALTH ALLIANCE
THE CHALLENGE:
ENSURING A GOOD EXPERIENCE AT THE DOCTOR'S OFFICE BECAUSE IT CAN LEAD TO BETTER HEALTH.
From scheduling an appointment to following up after an exam, Michael wants to make sure his expectations are met every time he goes to the doctor.
1 HE SEARCHES FOR A PRIMARY CARE TEAM THAT IS COMMITTED TO AN EXCELLENT PATIENT EXPERIENCE.
COMMUNITY CHECKUP
He goes to the Community Checkup to see how his clinic scored on the latest patient experience survey.
2 HE ASKS QUESTIONS AND TAKES NOTES.
Michael does his part by coming to his appointment with a list of questions and ready for discussion. He makes sure he understands what the doctor is saying before leaving.
3 HE KNOWS HE HAS OPTIONS.
If Michael's expectations aren't being met, he talks with his doctor about his concerns or looks around for a new doctor.
Patient experience focuses on the key patient interactions shown to be the most important to patients and linked to better health.
BECOME A SAVVY HEALTH CARE SHOPPER.
To find out how your medical group or clinic scores on patient experience, visit "Your Voice Matters" on the Community Checkup website at www.wacommunitycheckup.org/your-voice-matters.
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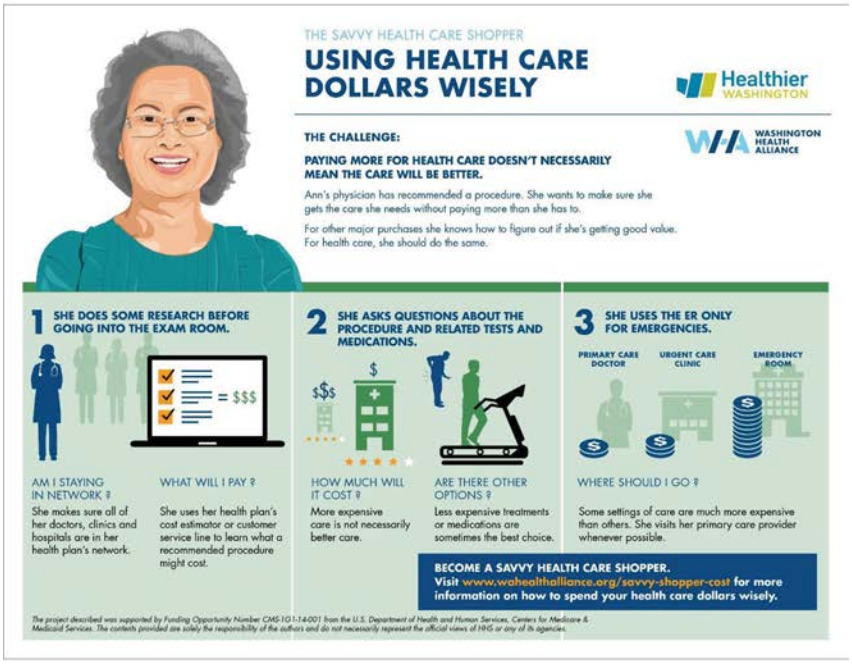
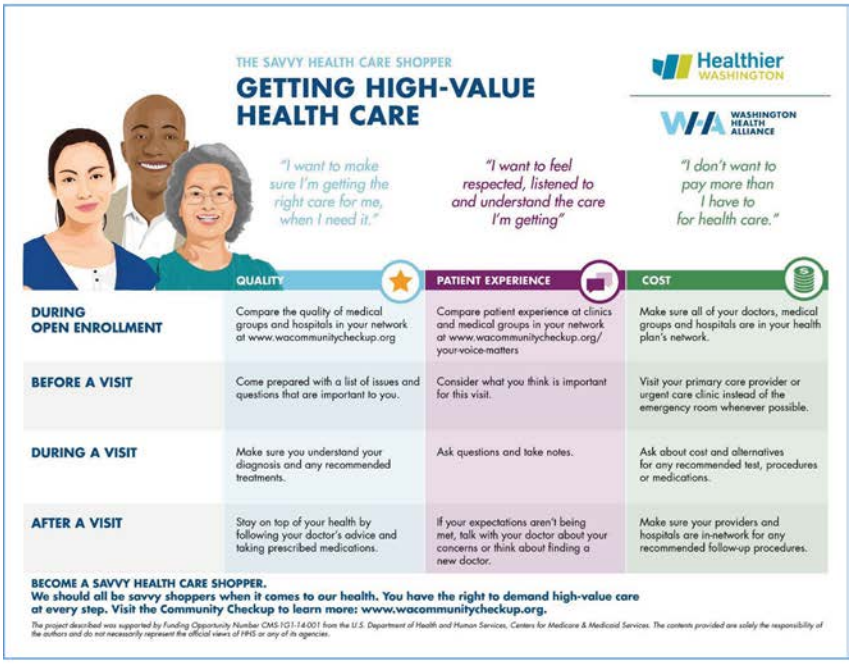
Appendix F


THE SAVVY HEALTH CARE SHOPPER
USING HEALTH CARE DOLLARS WISELY
Healthier WASHINGTON
WHA WASHINGTON HEALTH ALLIANCE
THE CHALLENGE:
PAYING MORE FOR HEALTH CARE DOESN'T NECESSARILY MEAN THE CARE WILL BE BETTER.
Ann's physician has recommended a procedure. She wants to make sure she gets the care she needs without paying more than she has to.
For other major purchases she knows how to figure out if she's getting good value. For health care, she should do the same.
1 SHE DOES SOME RESEARCH BEFORE GOING INTO THE EXAM ROOM.
= $$$
AM I STAYING IN NETWORK ?
She makes sure all of her doctors, clinics and hospitals are in her health plan's network.
WHAT WILL I PAY ?
She uses her health plan's cost estimator or customer service line to learn what a recommended procedure might cost.
2 SHE ASKS QUESTIONS ABOUT THE PROCEDURE AND RELATED TESTS AND MEDICATIONS.
$$$
$
HOW MUCH WILL IT COST ?
More expensive care is not necessarily better care.
ARE THERE OTHER OPTIONS ?
Less expensive treatments or medications are sometimes the best choice.
3 SHE USES THE ER ONLY FOR EMERGENCIES.
PRIMARY CARE DOCTOR
URGENT CARE CLINIC
EMERGENCY ROOM
WHERE SHOULD I GO ?
Some settings of care are much more expensive than others. She visits her primary care provider whenever possible.
BECOME A SAVVY HEALTH CARE SHOPPER.
Visit www.wahealthalliance.org/savvy-shopper-cost for more information on how to spend your health care dollars wisely.
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Appendix G


THE SAVVY HEALTH CARE SHOPPER
GETTING HIGH-VALUE HEALTH CARE
Healthier WASHINGTON
WASHINGTON HEALTH ALLIANCE
"I want to make sure I'm getting the right care for me, when I need it."
"I want to feel respected, listened to and understand the care I'm getting"
"I don't want to pay more than I have to for health care."
QUALITY
PATIENT EXPERIENCE
COST
DURING OPEN ENROLLMENT
Compare the quality of medical groups and hospitals in your network at www.wacommunitycheckup.org
Compare patient experience at clinics and medical groups in your network at www.wacommunitycheckup.org/your-voice-matters
Make sure all of your doctors, medical groups and hospitals are in your health plan's network.
BEFORE A VISIT
Come prepared with a list of issues and questions that are important to you.
Consider what you think is important for this visit.
Visit your primary care provider or urgent care clinic instead of the emergency room whenever possible.
DURING A VISIT
Make sure you understand your diagnosis and any recommended treatments.
Ask questions and take notes.
Ask about cost and alternatives for any recommended test, procedures or medications.
AFTER A VISIT
Stay on top of your health by following your doctor's advice and taking prescribed medications.
If your expectations aren't being met, talk with your doctor about your concerns or think about finding a new doctor.
Make sure your providers and hospitals are in-network for any recommended follow-up procedures.
BECOME A SAVVY HEALTH CARE SHOPPER.
We should all be savvy shoppers when it comes to our health. You have the right to demand high-value care at every step. Visit the Community Checkup to learn more: www.wacommunitycheckup.org.
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Appendix H

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

DR. ROBERT BREE COLLABORATIVE

Opioid Medication & Pain: What You Need to Know

If you've had an injury, surgery or major dental work, you are likely to have pain. Pain is a normal part of life and healing. Talk with your doctor about how you can get the most effective pain relief with the least risk.

NON-OPIOID PAIN TREATMENTS HAVE FEWER RISKS

For pain that will likely be gone in a week or two, it is always best to start with non-opioid pain treatments. Opioids may help control pain at first, but they are usually not necessary. Consider other options that may work just as well but have far fewer risks.

- Over-the-counter pain relievers
- Physical therapy
- Exercise
- Professional help coping with the emotional effects of pain

OPIOIDS ARE STRONG PRESCRIPTION MEDICATIONS

Opioids can be the right choice for treating severe pain, such as from cancer or immediately after major surgery. However, medications such as Vicodin, Percocet and OxyContin are very powerful and can be deadly. Even if you take them as directed, ALL opioids have serious side effects such as addiction and overdose.

OPIOIDS ARE CHEMICAL COUSINS OF HEROIN AND ARE HIGHLY ADDICTIVE

You can build up a tolerance to opioids over time, so you need to take more and more to get the same relief. The higher the dose, the more dangerous opioids are. You can even become addicted after a short time.

Commonly prescribed opioids:

- Codeine
- Dilaudid
- Fentanyl
- Hydrocodone (Vicodin)
- Hydromorphone
- Methadone
- Meperidine
- Morphine
- MS Contin
- Oxymorphone (Opana)
- Oxycodone (OxyContin)
- Percocet

These are only some of the prescription opioids. If you get a prescription for pain, ask your doctor if it is an opioid.

If you are prescribed an opioid for short-term pain:

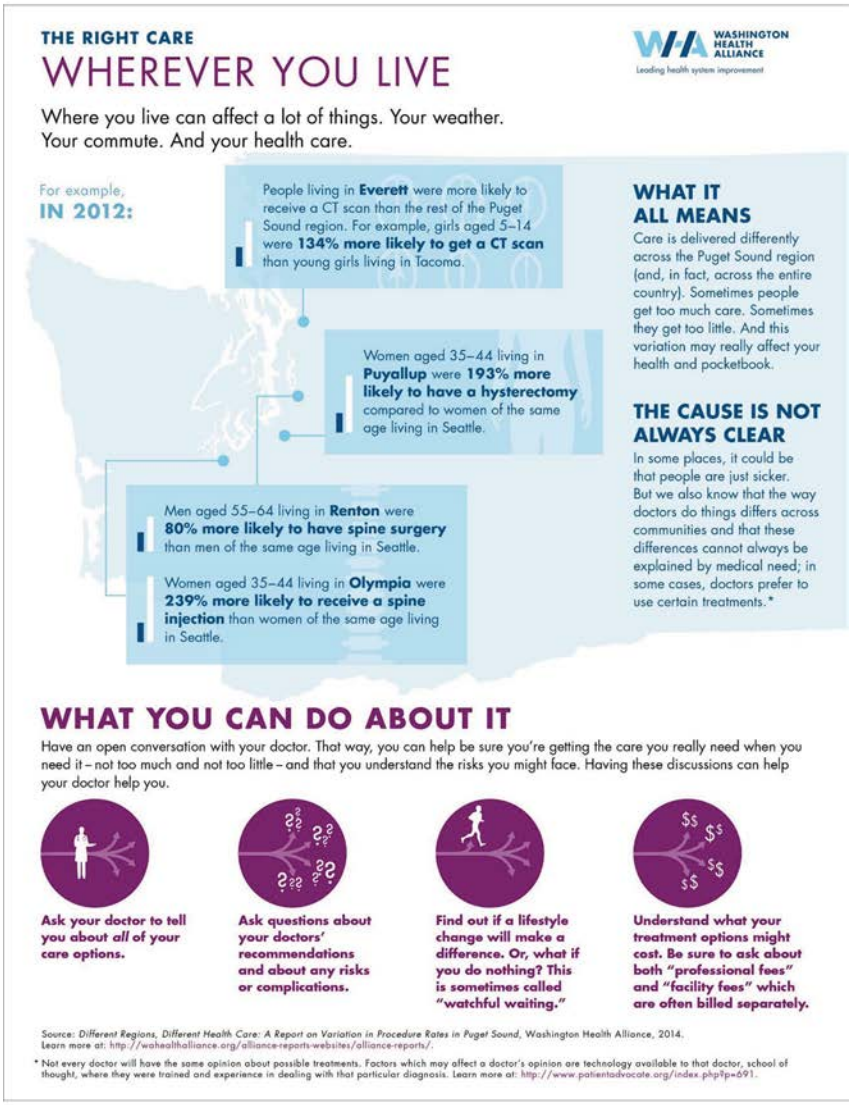
The prescription should only be for a three- to seven-day supply (often this is as few as 10 pills).

Take the lowest dose possible for the shortest period of time.

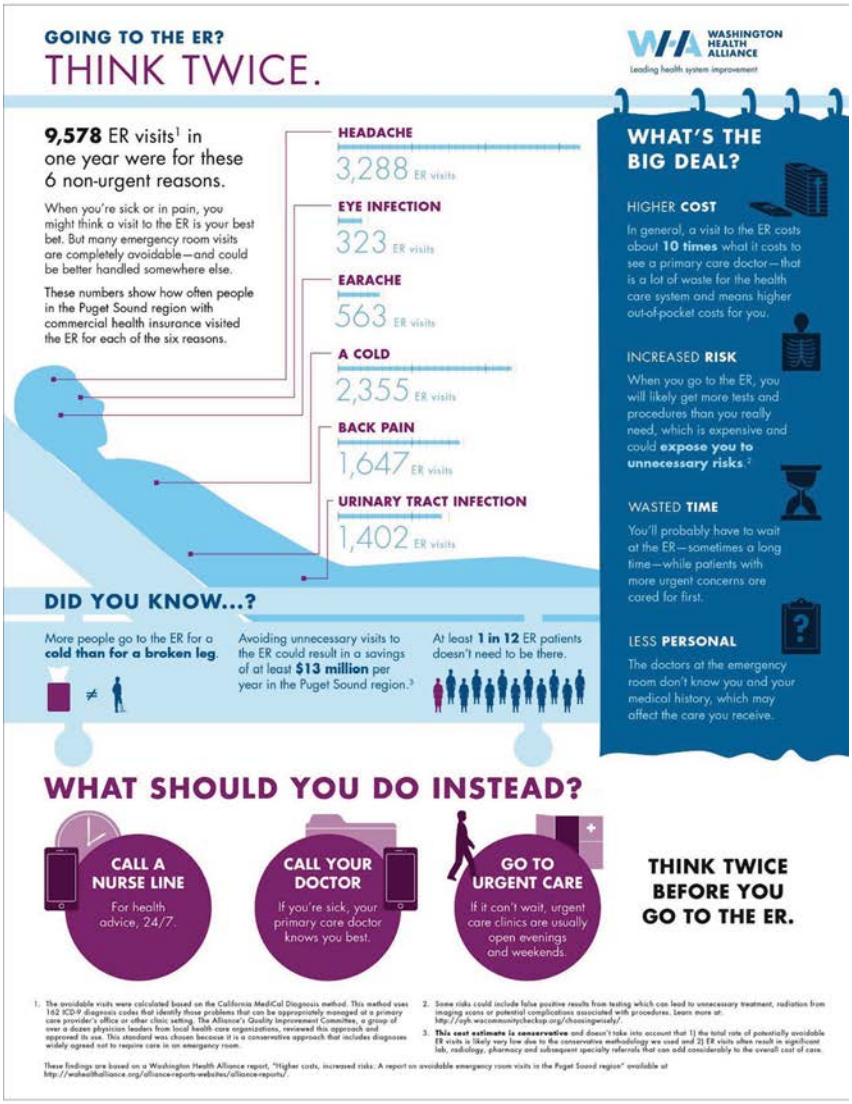
Always talk with your doctor about managing your pain better **without** taking prescription opioids.

www.WashingtonHealthAlliance.org www.BreeCollaborative.org

Appendix I


THE RIGHT CARE
WHEREVER YOU LIVE
WASHINGTON HEALTH ALLIANCE
Leading health system improvement
Where you live can affect a lot of things. Your weather. Your commute. And your health care.
For example,
IN 2012:
People living in Everett were more likely to receive a CT scan than the rest of the Puget Sound region. For example, girls aged 5–14 were 134% more likely to get a CT scan than young girls living in Tacoma.
Women aged 35–44 living in Puyallup were 193% more likely to have a hysterectomy compared to women of the same age living in Seattle.
Men aged 55–64 living in Renton were 80% more likely to have spine surgery than men of the same age living in Seattle.
Women aged 35–44 living in Olympia were 239% more likely to receive a spine injection than women of the same age living in Seattle.
WHAT IT ALL MEANS
Care is delivered differently across the Puget Sound region (and, in fact, across the entire country). Sometimes people get too much care. Sometimes they get too little. And this variation may really affect your health and pocketbook.
THE CAUSE IS NOT ALWAYS CLEAR
In some places, it could be that people are just sicker. But we also know that the way doctors do things differs across communities and that these differences cannot always be explained by medical need; in some cases, doctors prefer to use certain treatments.*
WHAT YOU CAN DO ABOUT IT
Have an open conversation with your doctor. That way, you can help be sure you're getting the care you really need when you need it – not too much and not too little – and that you understand the risks you might face. Having these discussions can help your doctor help you.
Ask your doctor to tell you about all of your care options.
Ask questions about your doctors' recommendations and about any risks or complications.
Find out if a lifestyle change will make a difference. Or, what if you do nothing? This is sometimes called "watchful waiting."
Understand what your treatment options might cost. Be sure to ask about both "professional fees" and "facility fees" which are often billed separately.
Source: Different Regions, Different Health Care: A Report on Variation in Procedure Rates in Puget Sound, Washington Health Alliance, 2014.
Learn more at: http://wahealthalliance.org/alliance-reports-websites/alliance-reports/.
* Not every doctor will have the same opinion about possible treatments. Factors which may affect a doctor's opinion are technology available to that doctor, school of thought, where they were trained and experience in dealing with that particular diagnosis. Learn more at: http://www.patientadvocate.org/index.php?p=691.

Appendix J


GOING TO THE ER?
THINK TWICE.
WASHINGTON HEALTH ALLIANCE
Leading health system improvement
9,578 ER visits[1] in one year were for these 6 non-urgent reasons.
When you're sick or in pain, you might think a visit to the ER is your best bet. But many emergency room visits are completely avoidable—and could be better handled somewhere else.
These numbers show how often people in the Puget Sound region with commercial health insurance visited the ER for each of the six reasons.
HEADACHE
3,288 ER visits
EYE INFECTION
323 ER visits
EARACHE
563 ER visits
A COLD
2,355 ER visits
BACK PAIN
1,647 ER visits
URINARY TRACT INFECTION
1,402 ER visits
WHAT'S THE BIG DEAL?
HIGHER COST
In general, a visit to the ER costs about 10 times what it costs to see a primary care doctor—that is a lot of waste for the health care system and means higher out-of-pocket costs for you.
INCREASED RISK
When you go to the ER, you will likely get more tests and procedures than you really need, which is expensive and could expose you to unnecessary risks.[2]
WASTED TIME
You'll probably have to wait at the ER—sometimes a long time—while patients with more urgent concerns are cared for first.
LESS PERSONAL
The doctors at the emergency room don't know you and your medical history, which may affect the care you receive.
DID YOU KNOW...?
More people go to the ER for a cold than for a broken leg.
Avoiding unnecessary visits to the ER could result in a savings of at least $13 million per year in the Puget Sound region.[3]
At least 1 in 12 ER patients doesn't need to be there.
WHAT SHOULD YOU DO INSTEAD?
CALL A NURSE LINE
For health advice, 24/7.
CALL YOUR DOCTOR
If you're sick, your primary care doctor knows you best.
GO TO URGENT CARE
If it can't wait, urgent care clinics are usually open evenings and weekends.
THINK TWICE BEFORE YOU GO TO THE ER.
1. The avoidable visits were calculated based on the California MediCal Diagnosis method. This method uses 162 ICD-9 diagnosis codes that identify those problems that can be appropriately managed at a primary care provider's office or other clinic setting. The Alliance's Quality Improvement Committee, a group of over a dozen physician leaders from local health care organizations, reviewed this approach and approved its use. This standard was chosen because it is a conservative approach that includes diagnoses widely agreed not to require care in an emergency room.
2. Some risks could include false positive results from testing which can lead to unnecessary treatment, radiation from imaging scans or potential complications associated with procedures. Learn more at: http://eyh.wacommunitycheckup.org/choosingwisely/.
3. This cost estimate is conservative and doesn't take into account that 1) the total rate of potentially avoidable ER visits is likely very low due to the conservative methodology we used and 2) ER visits often result in significant lab, radiology, pharmacy and subsequent specialty referrals that can add considerably to the overall cost of care.
These findings are based on a Washington Health Alliance report, "Higher costs, increased risks: A report on avoidable emergency room visits in the Puget Sound region" available at http://wahealthalliance.org/alliance-reports-websites/alliance-reports/.

[SUMMARY STATEMENT OF NANCY A. GIUNTO]

For the past 13 years, the Washington Health Alliance, (Alliance) has been bringing together organizations that share a common commitment to drive change in our health care system. As well as being a trusted convener for purchasers, providers, health plans, consumers and other health care partners in our state, the Alliance aggregates data for performance measurement and public reporting through its voluntary All Payer Claims Database (APCD).

Summary of Key Points

Transforming data into action requires multi-stakeholder engagement, a shared commitment to value-based purchasing and an environment that fosters trust, dialogue and communication from respected sources. To create the tools and action steps that ultimately result in better health, lower cost and less waste, we must first turn the data into information that is understandable and useable by multiple audiences—consumers, providers, payers and purchasers.

It is nearly impossible for consumers to navigate the current health care system alone. But providing tools and information that can empower them to choose high-value care requires that all health care stakeholders work together to create an improved system of care that benefits consumers. To engage stakeholders in this process, we must answer the questions, "how do we hold one another accountable for our collective commitments?" and "What's in it for me?" Our written testimony gives concrete examples of how to accomplish this balancing act and addresses how our reports were used by Alliance members and stakeholders to make impactful changes. We give examples of accomplishments from other regional health improvement collaboratives (RHICs) across the nation that are having positive impacts in the communities they serve as well.

Cost transparency is very important, but it is not enough. Ideally, reporting would include all aspects of value—cost, quality and patient experience. We must be able to look at cost and understand what we get for it. Does the expense improve the outcome of care? Is the expense clinically appropriate or is it simply a wasteful, overuse of care?

In addition, we offer four ways to further empower consumers to choose high-value health care:

1. Teach consumers that health care is measurable and highly variable and that they can be better consumers of care.
2. Focus on health literacy.
3. Deliver meaningful information, ideally at the time care is being sought or delivered.
4. Enlist physicians and other clinicians to help promote transparency.

What Actions Should Congress Take?

1. Create incentives across stakeholder groups to align on transparency initiatives and purchasing for value.
2. Support Federal agency initiatives that make health care data more transparent and focus on value.
3. Strengthen the role of RHICs in developing data sets and communicating health information.

The CHAIRMAN. Thanks, Ms. Giunto, and thanks for traveling across the country to testify.

Ms. GIUNTO. You're very welcome, Senator. My pleasure.

The CHAIRMAN. Mr. Tippets. You've come a long way, too, I guess.

STATEMENT OF TY TIPPETS, ADMINISTRATOR, ST. GEORGE SURGICAL CENTER, ST. GEORGE, UT

Mr. TIPPETS. Good morning. I'm honored to testify today, and thank you for the opportunity to represent my ambulatory surgical center, as well as 5,600 other Medicare certified ASCs that perform 15 million procedures each year.

I am the administrator of St. George Surgical Center in St. George, Utah. We perform approximately 4,500 procedures on 2,600 patients each year, not only for patients living in Utah, but from 36 states and Canadian provinces as well. Our commitment to patient safety has resulted in an extremely low .37 percent infection rate and an exceptional 99.6 percent satisfaction rate.

Since 2013, St. George Surgical has offered up front pricing on our website for over 220 procedures. We believe that by offering this information, we empower patients with the critical information they need to make the right choices about the healthcare they need.

Since posting prices online, our patient base has expanded. For example, we recently served a patient from Montana who needed a knee ACL reconstruction. After finding our price online, he called to make sure we did not have a typo. The best price he found in Montana was $30,000 just for the hospital. Our listed price, which is fully bundled and includes doctor fees, facility fees, and anesthesia, is $6,335.

We routinely see 60 percent to 80 percent in savings, sometimes higher, over other settings for the same procedures. Nationally, ASCs save Medicare approximately $2.5 billion each year; Medicare beneficiaries, $1.5 billion; and private payers, almost $40 billion every single year. Price, however, is only one factor in determining value. Lower prices must be combined with high-quality care and a safe patient environment.

In addition, patients must understand that higher costs do not always indicate higher quality. To that point, across the roughly 23,000 procedures on 13,000 patients performed in St. George Surgical Center since 2013, only five cases have reported infection. Our quality and patient safety rates are so good, in fact, that a prominent physician from Salt Lake City recently asked to have his staff visit our center to study best practices.

The ASC community is concerned that in terms of measuring quality to determine value, there is little uniformity across settings. If a patient can choose to get their care from either an ASC or a hospital, shouldn't it be easy for them to compare price, safety, and quality measures in both settings? Right now, they cannot.

As an example, in the Centers for Medicare and Medicaid Services Quality Reporting Program, only ASCs report on such adverse event measures as patient burns, patient falls, wrong-site surgeries, and hospital transfers. Since 2012, ASCs have been so consistent on these measures that CMS has proposed to eliminate them, citing, quote, "Measured performance among ASCs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made," unquote.

That conclusion usually leads a group like the Ambulatory Surgery Center Association, which advocates for ASCs, to declare victory and to move on. However, we believe these metrics are so elemental in terms of highlighting patient safety, we will ask CMS to keep them. In fact, we want the reporting to expand and to require us to report on adverse events for all patients and that other sites of service do the same.

As you will find in my written testimony, a growing body of academic research shows that ASCs are achieving equal or better out-

comes than other outpatient surgical facilities while saving billions of dollars for both patients in the public and private sector. If we are to truly empower patients to get the best value for their healthcare dollars, both price and quality data must be transparent, meaningful, and comparable across all settings.

Thank you again for inviting me to participate in today's hearing, and I look forward to answering questions from the Committee.

[The prepared statement of Mr. Tippets follows:]

PREPARED STATEMENT OF TY TIPPETS

I am honored to testify on the critical issues of price transparency and reducing health care costs. Thank you for the opportunity to represent my ambulatory surgery center (ASC) as well as the Ambulatory Surgery Center Association (ASCA), which represents the interests of the 5,600 Medicare-certified ASCs that provide 15 million outpatient procedures to patients across the country each year.

ASCs like mine are health care facilities that specialize in providing essential surgical and preventive services in an outpatient setting. ASCs have transformed the outpatient experience by offering a convenient, personalized and lower-priced alternative to hospitals.

I am the chief executive office and administrator for the St. George Surgical Center in St. George, Utah. We perform approximately 4,500 procedures on 2,600 patients each year—not only from Utah, but from 36 states and Canadian provinces as well. Our board-certified surgeons specialize in everything from general surgery to total joint replacements. Our commitment to patient safety has resulted in an extremely low 0.037 percent infection rate, and an exceptional 99.6 percent patient satisfaction rate.

Since 2013, St. George has offered up-front procedure pricing on its website for more than 220 procedures. We believe that by offering this information, we empower patients with the critical information they need to make the right choices about the care they require.

The demand for price transparency is real. Since posting prices online, our patient base has expanded. For example, we recently served a patient from Montana for a knee ACL reconstruction. After finding our price online, he called to make sure we did not have a typo in the price. The best price he found in Montana was $30,000, just for the hospital fee. Our listed price, which is fully bundled and includes doctor fees, facility fees, and anesthesia is $6,335. We routinely see 60 percent-80 percent savings—sometimes higher—over other settings for the same procedures.

ASC Cost Savings and Value

St. George is not an outlier in reducing costs. Nationally, ASCs save Medicare approximately $2.5 billion each year, Medicare beneficiaries $1.5 billion each year [1] and private patients and payers almost $40 billion every single year. [2] These savings are generated by procedures performed in the ASC instead of a hospital outpatient department (HOPD). For example, in 2018, the Medicare payment rate for cataract removal in a hospital outpatient department is $1,926.09. In an ASC, the same procedure is reimbursed at $991.95.

Price, however, is only one factor in determining value. Lower prices must be combined with high quality care and a safe patient environment. In addition, patients must be disabused of the notion that higher costs indicate higher quality. As health policy experts will tell you, there is no correlation between cost and quality in terms of health care outcomes.

To that point, across the roughly 23,600 procedures on 13,500 patients performed in St. George Surgical Center since 2013, only five cases have reported infection. Our quality and patient safety rates are so good, in fact, a prominent physician from Salt Lake City recently asked to have staff visit our center to study best practices.

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[1] Medicare Cost Savings Tied to Ambulatory Surgery Centers, University of California-Berkeley Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, September 2013 available at *https://www.advancingsurgicalcare.com/reducinghealthcarecosts/costsavings/medicarecostsavingstiedtoascs*

[2] Healthcare Bluebook and Health Smart, Commercial Insurance Cost Savings in Ambulatory Surgery Centers (2016) available at *https://www.ascassociation.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=829b1dd6—0b5d-9686-e57c-3e2ed4ab42ca&forceDialog=0.*

From the national perspective, ASCA was a strong proponent for the requirement enacted in 2014[3] that CMS develop a web portal for Medicare beneficiaries that would allow them to compare their costs for a procedure based upon the sites of service available to them. Since ASC fees for most Medicare procedures are roughly half of HOPDs, this could lead to patient decision-making that would produce significant savings for both them and the Medicare program. Unfortunately, that web portal has not yet been developed.

Quality and Reporting

The ASC community is concerned that, in terms of measuring quality to determine value, there is little uniformity across settings—if patients can choose to get their care from either an ASC or a hospital, shouldn't it be easy for them to compare price, safety and quality metrics in both settings? That is not the way things work now, and we need to address that.

At the federal level, differences between ASC and HOPD reporting systems make it impossible to compare quality and outcomes between the two settings. In fact, only ASCs report on such adverse event measures as patient burns, patient falls, wrong site surgeries and hospital transfers in the Centers for Medicare and Medicaid Services (CMS) Quality Reporting Program. The ASC industry actively lobbied both Congress and CMS to implement this reporting program and works cooperatively with regulators to ensure that meaningful information is collected.

Since the quality reporting program started in 2012, ASCs have been so consistent on these adverse event measures that CMS recently proposed to eliminate them from our reporting system, citing "measure performance among ASCs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made."[4]

That is usually a conclusion that leads a group like ASCA to declare victory and move on. However, we believe these metrics are so elemental in terms of highlighting patient safety, we will ask CMS to keep them. In fact, we want the reporting to be expanded, requiring us to report on adverse events for all patients—not just Medicare patients—and that other sites of service do the same.

Disparities in reporting also exist at the state level. In my home State of Utah, health care facilities are required to report a number of adverse events within 72 hours to the state. Utah is required by regulation to compile the aggregate data and publish a report in March of each year to the Patient Safety Surveillance and Improvement Program Advisory Panel. In comparison, 13 states do not require any adverse event reporting, and some states that collect data do not make it publicly available.

Patient Safety and Outcomes

A growing body of academic research shows that ASCs are achieving equal or better outcomes than other outpatient surgical facilities while saving billions of dollars for both public and private patients and payors.[5]

One recent study,[6] published in the Journal of Health Economics, concludes that "ASCs on average provide higher quality care for outpatient procedures than hospitals, and other research indicates that they do so at lower costs than hospitals." The data outlined in this study are risk-adjusted, as the authors state "results indicate that the positive impact of ASCs on patient outcomes accrues even to the highest risk group of patients."

Another study[7], published last year in the Journal of Shoulder and Elbow Surgery, showed that for total shoulder replacements, "no significant differences were found between the ASC and hospital cohorts regarding average age, preoperative

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[3] Sec 4011 of the 21st Century Cures Act. Pub. L. 114–255. 130 Stat. 1033. 13 Dec 2016.

[4] 83FR 37046. CY 2019 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Proposed Rule available at *https://www.federalregister.gov/documents/2018/07/31/2018–15958/medicare—program-proposed-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical*

[5] *https://www.advancingsurgicalcare.com/safetyquality/research*

[6] Munnich, Elizabeth L. and Parente, Stephen T. Return to specialization: Evidence from outpatient surgery market. (2018) Journal of Health Economics, (57):147–167 available at *https://www.sciencedirect.com/science/article/pii/S0167629617310743*

[7] Brolin TJ, etal. Outpatient total shoulder arthroplasty in an ambulatory surgery center is a safe alternative to inpatient total shoulder arthroplasty in a hospital: a matched cohort study. (2017) The Journal of Shoulder and Elbow Surgery, 26(2):204–208 available at *https://www.ncbi.nlm.nih.gov/pubmed/27592373*

American Society of Anesthesiologists score, operative indications or body mass index. No patient required reoperation. There were no hospital admissions from the ASC cohort."

Conclusion

If we are to truly empower patients to get the best value for their health care dollars, both price and quality data must be transparent, meaningful and comparable across all settings where care is available.

Specifically, the ASC community supports the following initiatives to create a more transparent and efficient health care system:

- Medicare and insurers should publicly post information about prices paid or the beneficiaries' out-of-pocket liability for procedures across settings, rather than in the traditional silos of facility type;
- Patients should be given information on providers in their area, including health outcomes, patient satisfaction, beneficiary cost-sharing and reimbursement to those facilities, in an easy-to-understand manner;
- Disclosed pricing information must be accurate and present the most meaningful comparison for consumer choice. Providers should have the right to appeal and correct any inaccuracies of posted information;
- All health care providers and facilities should publicly disclose, in a user-friendly format, all relevant information about the relative price, quality, safety and efficiency of health care as well as any other information that may impact care decisions, such as financial arrangements and clinical guidelines for treatment;
- Medicare, insurers and other payers should encourage beneficiaries and the physicians who refer patients to use lower-cost settings; and . Payers should seek innovative methods, such as tiered co-payments, to incentivize patients to seek care in the least costly setting that is appropriate for their treatment.

Thank you again for inviting me to participate in today's hearing, and I look forward to answering the Committee's questions.

[SUMMARY STATEMENT OF TY TIPPETS]

Price Transparency and Health Care Value

SGSC provides up-front pricing on its website for over 220 procedures, including eye surgery, orthopedics, spine surgery, gynecology surgery, colonoscopies and endoscopies, foot surgery and various general surgeries. SGSC typically offers 60-90 percent savings for the same procedure in similar sites of service. Nationally, ASCs save Medicare $2.5 billion dollars (and private insurers $40 billion) annually, as they are reimbursed roughly 50 percent as hospital outpatient departments for the same procedures.

Price, however, is only one factor in determining value. Lower prices must be combined with high quality care and a safe patient environment. In addition, patients must understand that higher costs do not indicate higher quality. A commitment to patient safety at SGSC has resulted in an extremely low 0.037 percent infection rate, and an exceptional 99.6 percent patient satisfaction rate. A growing body of academic research shows ASCs achieve equal or better outcomes than other outpatient surgical facilities while saving billions of dollars for public and private patients and insurers.

To empower patients to the get the best value for their health care dollars, both price and quality data must be transparent, meaningful and comparable across all settings where care is available.

Quality Reporting and Transparency

As part of the Centers for Medicare and Medicaid Services (CMS) Quality Reporting Program, only ASCs report on such adverse event measures as patient burns, patient falls, wrong site surgeries and hospital transfers. Since 2012, ASCs have been so consistent on these measures that CMS has proposed to eliminate them, citing "measure performance among ASCs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made."

As an industry, however, we believe these metrics are so elemental in terms of highlighting patient safety, we will ask CMS to keep them. In fact, we want the reporting to expand and require us to report on adverse events for all patients and that other sites of service do the same.

About Ambulatory Surgery Centers

ASCs are modern health care facilities that provide same-day surgical care, including diagnostic and preventive procedures. There are more than 5,600 Medicare-certified ASCs across the country. ASCs perform approximately 15 million procedures a year, including 6.4 million Medicare procedures. Roughly 55 percent of ASCs have one or two operating rooms. The five states with the most ASCs are California (800), Florida (425), Texas (375), Georgia (350) and Maryland (350). Tennessee has 138 ASCs and Washington has 200.

ASCs are represented by the Ambulatory Surgery Center Association (ASCA). ASCA provides advocacy and resources to assist members as they deliver ethical, high quality and cost-effective care within the community. Contact Heather Falen Ashby, Director of Government Affairs at 703–345—0286 or *hashby@ascassociation.org.*

The CHAIRMAN. Thank you, Mr. Tippets, and thanks to each of the four of you for very interesting testimony. We'll now go to rounds of questions.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman, and I just have a few before I have to get to the floor.

Ms. Giunto, let me start with you. A number of our witnesses talked about the need to make sure transparency policies are implemented in the right way, that transparency on its own can sometimes be confusing for patients, or worse, actually lead to higher healthcare—if you think, "I don't want a cheap product," and you go for the higher care.

So you said to get transparency policies right, information has to be translated to the audience and used to promote engagement and targeted—achieve specific outcomes. Tell us a little bit more about how Washington Health Alliance works with your stakeholders to make those reports effective and helpful for everyone.

Ms. GIUNTO. Thank you, Senator. We work with about 90 stakeholders a month, including our board of directors and four standing committees. The four standing committees represent clinicians, consumers, a health economics committee that's a multidisciplinary committee, and purchasers. All of our work happens through those committees, both what we study, the methodology that we use, as well as how we communicate to the consumer.

Oftentimes, we're making available two different reports, one for more—the public that is a health economist kind of public, and one for the consumer. I'll mention one, in particular, where we were coached by our consumer education committee on an opioid report where they told us that patients don't understand if they're on a brand name that they might actually be taking an opioid, and they said, "Please, when you develop this one-page infographic, put that front and center."

So we look for multi-stakeholder input for the work that do and work through the committee structure and our board.

Senator MURRAY. Okay. Thank you very much.

Ms. Binder, you talked about the importance of the Federal Government and employers working together to improve transparency, and you noted Medicare, the Centers for Disease Control and Pre-

vention, and other federal agencies and programs are increasingly requiring providers to expand the measures that they actually report on, and those measures are in turn reported to the public.

Talk to us a little bit about why these policies are so important to employers that make up the Leapfrog Group.

Ms. BINDER. The example I'll use is infection measures. It took us decades, literally, to achieve the public reporting of five of the most common and deadly infections, such as MRSA, C.diff. These are infections often associated with and caused by being in the hospital, and they are extremely dangerous, and they kill a lot of Americans every year.

They are also costly. So employers—we have started to track an estimate of the cost to employers. On average, it's about $9,000 per inpatient stay for every inpatient stay that is paid for the excess cost of errors and accidents in hospitals, including infections. So it is a very expensive problem for employers and also hard to track, hard to find it in the claims. So we really depend on CMS and CDC, in particular, to help us identify the rates of these infections so that employers can steer employees toward the higher performing hospitals.

There's been some effort to pull us backward in that direction. I think that CMS has recommitted recently to public reporting of infection rates, but we remain concerned. There was a proposed rule that came out from CMS last spring that suggested that they would stop public reporting of those five measures. We were very concerned. A lot of purchasers came forward as well as consumer advocates to ask that they not do that. They have recommitted to transparency. But, again, we are continuing to worry about that.

Yesterday, there was another proposed rule issued by CMS suggesting that CMS is placing a high priority on provider burden in collecting infection measures. Again, we believe that there's also a burden on our entire economy by having so many infections, and that we ought to also put a priority on the American public and what they need to know and deserve to know about how their hospitals are doing.

So I would ask this Committee, especially in your jurisdiction over CDC, that we would love to see CDC publicly report the measures they're collecting. They're doing a great job through NHSN, and we would like to see that publicly reported, which would enable us to have, I think, peace of mind and also help employers and purchasers in their efforts to ensure their employees are getting the safest care.

Senator MURRAY. Thank you. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Cassidy.

Senator CASSIDY. Thank you, Senators Alexander and Murray, for holding this meeting.

I'm a doc, a physician, and so I always think if you give the patient the power, including the power of knowledge and price, it makes a huge difference, both in terms of our health and our pocketbook. I would add the power of quality outcomes, the power of many other kinds of transparent information you all advocated. In

fact, I agree with each of you so much, I can't really challenge you. I almost have to ask you to amplify where we're going together.

I'll also point out that you have bipartisan support. We have been working with Senators Bennet, Young, Grassley, Carper, and McCaskill to do a price transparency working group, and if I have time, I'll refer to something that Senator Smith and others are working on as it regards administrative overhead. I could go on.

Let me first, though, speak about surprise medical billing. This is something I'm concerned about.

[Chart shown.]

Senator CASSIDY. The darker the color, the more likely that somebody is going to an in-network facility with an out-of-network provider, and they think they're doing the right thing, because they go to their hospital that they know is in-network. But the ER group, for example, or the anesthesiologist—Mr. Tippets, you mentioned specifically that anesthesiology is looped in. Their anesthesiologist when they go to surgery is not in.

So as much as 25 percent of inpatient bills—I think it's 50 percent—is it 50 percent for ER use? In these areas, including Alaska, Senator Murkowski, 50 percent of the time when somebody goes to an in-network hospital, they have an out-of-network ER charge, which can be dramatically high.

Seeing your concerned look, Senator Murkowski, I know I have a co-sponsor.

[Laughter.]

Senator CASSIDY. But we see it's all over, including Oregon. So I didn't expect that. Tennessee looks okay, Mr. Chairman. No, Tennessee is up there as well.

So that said, we are introducing a bill today which would attempt to address surprise medical billings in all its permutations to protect the provider in this setting. And, by the way, this is independent of the sophistication. I will say that once I went to Central Park in New York with my daughter. In full confession, I wasn't watching her. She falls off Alice in Wonderland, and then we have a trip to the ER with a surprise medical bill. My wife and I, a general surgeon and a gastroenterologist—we did not pick up on that.

So that said, Mr. Kampine, any thoughts you have about surprise medical billing and what we can do to address that?

Mr. KAMPINE. Thank you, Senator, for taking a look at this issue. It is a huge issue. You know, patients have a fighting chance if it's non-emergency care. We can help educate them and instruct them to speak with their doctor, call the hospital, ensure that the anesthesiologist—and that's a great example, right, because in an emergency case, your anesthesiologist might be working local times and is out-of-network, and, as a patient, you have no idea this is going on.

So if it's scheduled care, at least the patient has an opportunity, if they're educated, to talk to their doctor and talk to the hospital and make sure that everything is in-network. Something does have to be done about it. I'm actually a little surprised by your chart. My understanding is the State of Texas does have—and some states are handling this on a state level—the State of Texas does have some protections, I believe, for patients that are in HMOs, not

PPOs, and I was a little shocked to see how red that was in your graph.

It's absolutely something that needs to be addressed. I think if it can be addressed with legislation so that if you, for example, use an in-network hospital, and if there is a—end up with a balance bill for an out-of-network anesthesiologist or pathology, that you are limited to what your network rate would be, and you'd be limited on the out-of-pocket, and I think that is well worthwhile, exploring that legislation.

Senator CASSIDY. Let me stay with you on my next chart.

[Chart shown.]

Senator CASSIDY. I pulled this from your testimony. The price variation for south Florida cataract surgery fees—tenfold difference between the low and the high.

Mr. KAMPINE. Correct.

Senator CASSIDY. It seems principally facility fees.

Mr. KAMPINE. Correct.

Senator CASSIDY. It is just amazing that from less than $2,000 all the way to $12,000—it is quite remarkable.

Now, one thing that—I had a conversation this morning with somebody, and although Medicare is beyond the scope of this Committee, still, it's worthwhile considering. What if we made it possible for MA plans to share savings with beneficiaries who signed up for Medicare, if the beneficiary chooses a lower-cost facility, making sure that she has the information on infections and quality and everything else that everyone else spoke to—your example of the hip replacement—quite remarkable, Mr. Tippets. What are your thoughts about that, Mr. Kampine?

Mr. KAMPINE. Excuse me. I think that Medicare Advantage plans would embrace that, and I can tell you, just very quickly, my wife runs primary care medical home models for Medicare Advantage plans. Because they are at risk for this, they use tools like Healthcare Bluebook to make sure that they're guiding their patient to cost-effective—even in the Medicare environment, because there's a difference in the price, for example, for imaging.

I do think that there is absolutely promise. We know in the commercial environment that value-based incentives are incredibly important. There's been a lot of state legislation in terms of right-to-shop laws. We do it with—over 50 percent of our clients use incentives to reward patients when they make more cost-effective choices. It works. It's very successful, and I believe, absolutely, there's an application for it in the Medicare Advantage environment.

Senator CASSIDY. So this would be a win-win. Both the beneficiary would win, but also Medicare trust fund would pay far less, potentially.

Mr. KAMPINE. Absolutely, and the plans that sponsor MA.

Senator CASSIDY. The plans. I yield back, and I assume there'll be a second round, so I'll hang around.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

So transparency is part of any competitive market. If a consumer doesn't have good information, like price or quality, then let's just

be frank. It's impossible to shop around at that point. Without transparency, we know that businesses can jack up prices, they can cheat customers, and they never face the discipline of a competitive market.

It's clear that the healthcare market could benefit a lot from transparency. Transparency lets patients shop for a doctor that's right for them, compare prices across hospitals, know which providers have the best outcomes. But transparency can't solve every market failure, and there are a lot of features of our healthcare system that need to work if we're going to improve care. So I want to talk about where transparency can help and where it can't.

Mr. Kampine, your company, the Healthcare Bluebook, estimates fair prices for various healthcare procedures to help consumers benchmark what they should be paying, and you do this for hundreds of procedures, and I want to look at just one.

Mr. KAMPINE. Sure.

Senator WARREN. Total hip replacement. What's the fair price for a total hip replacement?

Mr. KAMPINE. So the fair price—the way we do our analysis of prices is we look market by market, and——

Senator WARREN. Sure.

Mr. KAMPINE.——and, typically, we look at a metropolitan area. So the fair price is going to vary by market, as you pointed out. The competition in that local market will have an impact on where the prices fall.

Senator WARREN. So about what's the price?

Mr. KAMPINE. So, roughly, if you were to look across the United States, a very common fair price for a hip replacement would be about $30,000.

Senator WARREN. Okay. About $30,000.

Now, Mr. Tippets, you run a surgical center in Utah that has been increasing transparency by actually posting the prices of procedures on your website. What's the expected cost of a total hip replacement at St. George?

Mr. TIPPETS. For that total hip replacement, it would be $17,985, including the doctor, the facility, anesthesia, implants, and overnight stay.

Senator WARREN. So $30,000 is fair. That's just the average, and you're down by posting at $17,985. I don't want to leave the $85 out. Okay. So that's pretty impressive, obviously well below the fair price, a good deal for patients who can pay out of pocket. Because St. George's website includes a disclaimer that if you aren't paying cash for a procedure, meaning if you have to use insurance to help pay for the hip replacement, the price may actually be different.

So let me ask another question. How many of your patients are actually able to pay out of pocket for their surgeries?

Mr. TIPPETS. Right now, about 10 percent of our patients utilize the cash pay pricing.

Senator WARREN. So only about 10 percent. So it's great that you are able to keep prices low and transparent for patients who pay out of pocket. But if we want people to be able to afford a hip replacement, transparency alone is just not going to get them there. Most Americans don't have enough money to pay cash out of pocket

for a hip replacement or an expensive—any of these expensive procedures. They need affordable insurance coverage.

Twenty-eight million people in this country have no health coverage at all. Forty-three percent of those who do have coverage struggle just to pay their deductible. So, obviously, not going to work perfectly here.

Let me ask about one other kind of transparency, transparency around hospital and provider performance.

Ms. Binder, your agency, the Leapfrog Group, reports hospital safety and quality information so that individuals and their families can make the best decision about where to get their care. What good is this comparison tool if you have only one provider in your network?

Ms. BINDER. Well, I happen to have lived in a community where there was only one provider. I happen to have worked for that provider. It was a rural community in Maine, and this is what's good. You know everyone. When you live in a community with only one provider, we know everyone, and when our hospital—when I lived in this rural community, when our hospital didn't do well on something and it got publicly reported, which did happen a couple of times, wow, everyone talked about it, including stopping you in the grocery store and saying, "What happened to your hospital?" And guess what? That had a big impact.

For anyone who knows healthcare, you'll know this is dramatic. The physicians called a special meeting in the morning. Physicians never call meetings. Believe me. They don't like them. So they called one because they got a poor rating from Leapfrog, actually. That's how I first learned about Leapfrog.

So I think that even in the areas where there's not many choices, having transparency and public reporting can actually have quite an impact, because people talk to each other.

Senator WARREN. So, look, I hope that's the case. I genuinely do. But we have to be realistic here. When a health plan has all the power over whether or not you can get quality care, information on price and transparency alone are not going to solve the problem. You may get blips where people will pay attention, but it's not going to solve the problem.

Earlier this year, I introduced the Consumer Health Insurance Protection Act. There's a lot in this bill to increase transparency on how insurance companies set rates, which providers are in a network, and who gets the most complaints. But the bill also makes health coverage more affordable and brings health plans to the market. Part of this is to get more competition in these markets so that these insurance providers actually have to compete for customers.

If we're going to improve healthcare coverage in this country, then I think we've got to look at all the pieces together and try to make them work together. But thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. Thank you to the panel this morning.

There's been a lot of discussion as we have looked to differing ways that we can help families when it comes to healthcare costs. I've been working with a colleague of mine on making sure that we are able to have health savings accounts that are robust enough to help cover those costs. But in fairness, if I have a good nest egg of an HSA sitting over here, but I don't really have an ability to shop wisely and use those saved dollars wisely, what are we doing? So this conversation here this morning is so very, very important when we talk about transparency.

In my hometown of Anchorage, the largest city in the state, last year, we passed an ordinance that requires our healthcare professionals and our facilities to provide cost estimates to patients who request the information. They have to post it. They have to provide information within a certain number of days. Granted, it is still very early, but at this point in time, it doesn't appear that it's had much of an impact. Some of that is due to those issues that we've already heard, the difficulty of predicting services during an episode of care, varying insurance benefit structures, bills from multiple providers, and the like.

But to Senator Warren's comment, I live in a state in a place—Anchorage, again, is our biggest population center, but we just don't have a lot of competition. So if you're looking to go to the hospital in Bethel, there's no real point in shopping around because you've got one, and the same is true in just about every community outside of Anchorage, Alaska. So I looked with great interest at the chart that Senator Cassidy showed in terms of the cost, the facility cost, and how those weigh in.

But the question that I wanted to ask you all this morning is—we're moving towards greater transparency, whether it's through Bluebook or through other mechanisms. Maybe it's going to start out slow, but we are moving in the direction of better ability to obtain access to the pricing.

But what's the role here for Congress? How does Congress mandate the education and the engagement parts that are so critical to this? Because if you've got a situation where, "Oh, my gosh, I am not well right now, and I feel it, and I don't know what may happen. Am I going to have a heart attack? I don't know." Does that mean that I start shopping around now while I'm feeling ill? Do I just—am I one of these people that is going to look at my health, my family's history, and say, "I'd better do my own analysis early on, because within the next 10 years, I'm likely to need some of these services for cardiology in my community."

How do we engage people early enough to make a difference? Because most folks are going to have a hard time engaging on a topic that they may not need, and that everyone hopes that they're not going to need? What advice do you have here? Because it seems that so much of what we're doing is kind of after the fact or at the very minute that something is happening. Who can educate me here?

Ms. Binder.

Ms. BINDER. Well, I would just say that the role of government should actually be as narrow as possible in looking at this issue.

Senator MURKOWSKI. Sure.

Ms. BINDER. I think the role of government is to ensure that the data and information is scientifically sound, reliable, and available, and then make that available to public entities like all of us, and then we can—we have an incentive to reach out to the public and engage them. I think there's a lot of private sector entities both in the for-profit and not-for-profit space who have a lot of interest in going out and reaching consumers.

Senator MURKOWSKI. So you're saying you do the engagement rather than me, the consumer.

Mr. BINDER. Right. But we need the data, and that's what we're missing. We need more data, much more publicly available data that we can use, and that's where I think there's a role for government.

Senator MURKOWSKI. Others? Ms. Giunto.

Ms. GIUNTO. I would offer two suggestions. First is help us all teach consumers that healthcare is shoppable. I think that many consumers still don't understand that, so whatever you can do to help us teach consumers that healthcare is shoppable.

I would also say there are many organizations, like the Alliance, called regional health improvement collaboratives around the country that have all of the stakeholders convened around the table to try to work on this issue in their local environment. And when things get solved locally with people who all have skin in the game, it's an opportunity for improvement.

Mr. KAMPINE. If it's okay, I'd like to weigh in. This is probably the biggest learning over the past 10 years. Most people are healthy most of the time, and so they don't think about this, and it's key to educate up front. What we know is that if consumers know they need to shop and they know prices vary and they know quality varies, then they'll shop, and then they'll get better value. But you can't do it at a rifle shot. It has to be continuous. So someone with heart disease has to know about this issue when they ultimately need to consume, and people with other conditions as well.

So a steady drumbeat of regular communication—I do think we do that—that's our responsibility. But we need the data, obviously, to be able to do that, but that is probably the biggest key of learning, is making sure that there is a regular drumbeat of education so that people understand this when they do need to consume.

Senator MURKOWSKI. Mr. Chairman, I have to wonder how much of this is generational, because I think in our generation, we didn't have the ability to shop. We didn't know that we could. I think young people can look at this and say, "Yes, you shop for everything."

Thank you.

The CHAIRMAN. Thanks, Senator Murkowski.

Senator Smith.

Senator SMITH. Thank you, Chair Alexander, and I want to thank you and also Senator Murray for these hearings. They've been so helpful and interesting.

For me, like I think many of my colleagues, healthcare cost is the number one issue that I hear about from Minnesotans. So I really appreciate all of your testimony on this.

In previous hearings, we've had a lot of conversation about how simplifying our healthcare system and making it more transparent

could help eliminate wasteful spending and lower costs for families and the healthcare system more broadly. And with this in mind, my colleague, Senator Cassidy, and I have introduced a bill that is focused especially on administrative costs and trying to figure out how to lower the administrative cost burden, which some estimate could be up to 25 percent of the total cost of healthcare.

This bill is aimed at streamlining healthcare administration and cutting cost and easing the burden on healthcare providers as well as patients. What it does is it builds on a successful effort in Minnesota to automate these common, high-volume healthcare transactions, like prior authorizations, for example, or when—any time a provider submits a bill to insurers. In Minnesota, this is projected to save somewhere in the neighborhood of $60 million, which is a lot for us.

So my question—and maybe I'll start with you, Mr. Tippets. My question is: Could you—really, I'm interested in everybody's perspective, though. In what ways could efforts to streamline and automate administrative and clinical systems help to improve transparency, in your experience?

Mr. TIPPETS. You know, as an ASC, we already have to run very tight ships with low overhead. I don't think that that's an area of expertise that an ASC—that we would have. But what we do recognize, especially, even though we encourage reporting, I think that the overall burden sometimes in reducing paperwork and reducing burdens would assist with lowering the cost of administrative healthcare.

Senator SMITH. Would others like to comment on this? I mean, it seems to me that if we have more billing and administrative costs, transactions automated, that we would be able to—patients would have better real-time information about how much things cost. What would others say?

Ms. GIUNTO. I would say, Senator, that I agree with you, and I would just stretch a little bit to think about administrative overhead and the way we think about the clinical work and effort that goes into measuring and reporting to the multitude of agencies about measuring on clinical reporting. Many healthcare deliverers have lots of staff to do this work, and if we could get to a point that we had closer common agreement on the measures that really impacted quality and that's what we focused on, I think we'd be ahead.

Senator SMITH. So it could actually help with the data gathering as well as the transparency of understanding how much stuff costs.

Ms. GIUNTO. Just how many staff are dedicated to the effort within institutions.

Senator SMITH. Right. And based on your work, do you think this could help patients avoid unnecessary out-of-pocket costs, too?

Ms. GIUNTO. Yes, I do.

Senator SMITH. Let me ask something—it's sort of getting at something that my colleague, Senator Murkowski, I think, was getting at as well. So we've traveled all over—as I travel all over Minnesota, people are talking about how much they want more transparency in their—in how much things cost. For example, there was one woman named Leah in Mankato who shared her frustration that she couldn't get an estimate for how much it was going to cost

her to deliver her baby. This was her first child. This was a huge source of stress for her and her family—how much is this going to cost? I talked to another man who needed to have polyps removed from his nose, and nobody could tell him how much this was going to cost.

So let me stay with you, Ms. Giunto. Could you talk a little bit about how increasing this kind of transparency is going to help patients make better decisions? What I'm getting at is what I think maybe Senator Murkowski was getting at, which is it's so hard to know, like, what questions to ask, even, when you're trying to—it's so complicated. It's so—not all of us are Senator Cassidy, who knows a lot about this sector.

Ms. GIUNTO. So working with our Healthcare Authority in the State of Washington, Senator, we put together a very simple series called the Savvy Shopper series—it's a part of my written testimony—where on a single page, we helped consumers looking for cost, quality, and patient experience. Think about the very simple questions to ask of their physicians or their care providers. And in the end, we put that all together to talk about getting value in healthcare.

These are things that employers in our state put on their websites, introducing their wellness programs. Our State of Washington has this information available for their employees and Medicaid patients. So I really do think it starts with just the focus on education. And as we get more sophisticated and continue to do our work, all of us on the panel, making this information much more transparent and having individuals speak up and ask the questions—What does this cost? Is this a high-quality provider? Have people had great patient experiences with this provider?—that will put us ahead.

Senator SMITH. Thanks very much.

Thank you, Chair.

The CHAIRMAN. Thank you, Senator Smith.

Senator Kaine.

Senator KAINE. Thanks, Mr. Chair, and I also agree with Senator Smith. These hearings have been very helpful.

Mr. Tippets, your testimony in response to Senator Warren's question really interests me, and I want to ask about your own St. George Ambulatory Surgery Center. So let's talk about hip replacements. If the price is $17,985—is that right?

Mr. TIPPETS. That's correct.

Senator KAINE. For cash. What is—and that is the amount that the patient pays and that is the amount that the center receives. What do you receive when you do a hip replacement for somebody who is a Medicaid patient?

Mr. TIPPETS. Unfortunately, as an outpatient procedure, an ASC is not approved for Medicare or Medicaid yet.

Senator KAINE. That is not approved by CMS?

Mr. TIPPETS. CMS. That's correct.

Senator KAINE. So they will not approve that for an outpatient facility, either an ambulatory surgery center or a hospital outpatient?

Mr. TIPPETS. Right now, I believe the only total joint is knees that has been approved on an outpatient, but only to hospital outpatients, not to ASCs yet.

Senator KAINE. So this is an interesting phenomenon, because you, in your testimony, talked about the quality of hip replacements performed and other procedures performed in ambulatory service centers. In your view, should CMS authorize outpatient hip replacements at ambulatory service centers?

Mr. TIPPETS. Absolutely. We've got studies attached to written testimony how in all procedures we are equal to or superior to hospitals. And I need to address that not all outpatients should end up in a surgery center——

Senator KAINE. Right.

Mr. TIPPETS.———because of comorbidities, because they are maybe too old, or—there's lots of reasons why they need to go to the hospital. But a healthy individual coming through, especially if it were going to be Medicare or Medicaid, could save the taxpayer and the individual thousands of dollars.

Senator KAINE. So while not every hip replacement should be performed in an ambulatory service center——

Mr. TIPPETS. That's correct.

Senator KAINE.——you would take the position that CMS should not bar them from being performed.

Is there any disagreement with that on the panel? Should CMS allow hip replacements to be done under certain circumstances in ambulatory service centers?

Ms. BINDER. As long as we have data on whether they're safe. We don't have data right now and——

Senator KAINE. Well, if they're not allowed to be done, then you're not going to have the data.

Ms. BINDER. Well, they are being done, but——

Senator KAINE. But if they are being done, it sounds like there is data about the quality measures of hip replacements done in ambulatory service centers.

Ms. BINDER. Right, but they need to be monitored by an independent entity of some sort. Right now—and to the credit of ASCs, they're asking for this to happen.

Senator KAINE. Right.

Ms. BINDER. But they need an independent entity to monitor what they're doing. So they are doing it for commercially insured populations, and that's good, and we need to see that data, and it needs to be verified, and that's when Medicare should cover—that's what they should be looking at before they're all in.

Senator KAINE. If the price is $17,985 for somebody paying cash, and that's what they pay, and that's what you receive, what do you receive if you perform a hip replacement for somebody with private insurance, and does it vary by the insurance company that insures the patient?

Mr. TIPPETS. Well, we just started our outpatient hip not too long ago. But, unfortunately, most of the commercial payers will follow closely the Medicare/Medicaid procedures. So I think we'll see a rush of—once those are approved and hopefully approved—the total hips and Medicare and Medicaid—then I think the major commercial payers will then bring those in. We would receive——

Senator KAINE. How about this. Let me switch to another procedure—knee replacements. Have you been doing those longer?

Mr. TIPPETS. We've been doing those a little bit longer.

Senator KAINE. Do you have private insurance covering some of your knee replacement patients?

Mr. TIPPETS. Most of our knee replacements have been cash pay.

Senator KAINE. Are there procedures that you currently perform where you have a patient mix that includes cash pay, private insurance, Medicaid, or Medicare?

Mr. TIPPETS. We don't bundle those, and so—I mean, for those three things. One of the reasons——

Senator KAINE. I think I saw in your testimony you have about 220 procedures where——

Mr. TIPPETS. We do.

Senator KAINE.——you will post a price.

Mr. TIPPETS. That's correct.

Senator KAINE. Are any of those procedures where you provide the procedure both to cash, private pay, Medicaid, and Medicare?

Mr. TIPPETS. Yes. We do all those. For example, we just did a hysterectomy from Virginia Beach—flew across the nation for $7,445. That's the cash pay.

Senator KAINE. If somebody came, and they were a Medicaid patient and wanted a hysterectomy, would you receive more or less than $7,445?

Mr. TIPPETS. The challenge there is we don't bill for the doctor. The doctor bills for their own, and often the anesthesiologist——

Senator KAINE. Do you know whether the total cost is more or less than $7,445?

Mr. TIPPETS. I know what our cost would be for a hysterectomy like that—would be about $4,000 we would receive from——

Senator KAINE. Then do you have a sense about what the cost for the other professionals are? Do you know whether the total cost is more or less than $7,445?

Mr. TIPPETS. I don't know what the doctors would charge or bill for that. So I don't have all the information to equate what a cash pay price would be to a commercial or Medicaid——

Senator KAINE. So even within your own pro-transparency network, you're not aware when you're treating patients whether they are being treated equally with respect to the cost that they are being charged or what the medical professionals are receiving for a particular procedure.

Mr. TIPPETS. That's correct. Right. I'm not—I can guess——

Senator KAINE. How about in private insurance? Do you bundle on the private insurance side if you perform a hysterectomy, and is the bundled cost—the bundled amount that you receive more or less than $7,445?

Mr. TIPPETS. We receive less than $7,445 based on—the doctor is not in the picture. So, essentially, the only thing that we would bill for is the facility fee only.

Senator KAINE. But I guess the gist of your testimony must be that the only reason people would pay cash is it's a discount. So if you're not aware of what the bundled total is, you nevertheless are setting a bundled payment, cash only, with the assumption that somebody would make that payment to you because it would

be less than the combined effect of the payments charged in another manner, correct?

Mr. TIPPETS. Well, we can equate that to if they go to a hospital. We know that, historically—we get the information from there—we're anywhere from 60 percent to 80 percent, sometimes less, than what a hospital fee—just for the facility fee.

Senator KAINE. Now, are you talking about an HOP—an outpatient——

The CHAIRMAN. We'll go to a second round.

Senator KAINE. Oh, I'm sorry. Excuse me. Thank you.

The CHAIRMAN. Go ahead and finish your answer.

Senator KAINE. Well, actually, I had finished that. I had finished.

The CHAIRMAN. What I'm going to do is I'm going to ask—I've got a couple of questions, and then I'm going to ask Senator Cassidy to chair a second round of questions, if that's all right with him, for any Senator who wishes to stay.

Mr. Tippets, following up on Senator Warren's question, I think you said that about 10 percent of the procedures were cash payments. Is that right?

Mr. TIPPETS. That's correct.

The CHAIRMAN. But that doesn't mean that those people had no insurance. Isn't that correct? It might have been cheaper for them to pay cash than to pay the deductible for the insurance they have. Am I correct about that?

Mr. TIPPETS. That's correct. What we're seeing, especially with high deductible HSAs, is they don't want to burn through in a year all of their deductible or co-pays on one hernia, for example, that would cost $3,000 bundled, where it might cost $15,000 to $20,000 in a hospital.

The CHAIRMAN. So do you have any guess about what percent of the people who pay cash at your center also have insurance that they don't use?

Mr. TIPPETS. I think it would be very low. I don't have the exact statistics, but individuals paying cash usually do not have insurance but they have the means to do so or they have high deductible plans.

The CHAIRMAN. Well, let me move to this question. Generally speaking, 55 percent or 60 percent of Americans—well, most Americans are insured. More than 90 percent have insurance. Fifty-five or 60 percent of those who do have insurance have employer insurance. They get it on the job. Maybe 35 or 40 get it from Medicare and Medicaid.

So am I correct—we have mandates from Washington about transparency on cost and quality for Medicare and Medicaid, but not for employer-sponsored insurance, correct?

Mr. TIPPETS. Correct.

The CHAIRMAN. How useful—I have two questions. One is how useful are the current federal mandates on government-sponsored insurance? I mean, can a consumer really figure anything out from those, or do they need to be re-written or made more meaningful? And, two, should the Federal Government create similar mandates for the 55 or 60 percent of the policies that are employer insurance?

Let's start with you, Mr. Tippets, and anybody else who wants——

Mr. TIPPETS. Great question, Senator. What we're seeing, especially with high deductible plans, is we're seeing more and more individuals have these excessive burdens on them. So what we're seeing is a more consumer driven system where they're becoming more educated, not just on price and quality, to deal with these issues. Because that's being driven by the consumers, the insurance companies and many private employers are going to self-funded plans to where they actually participate in price transparency and cash pay programs. What is beneficial in that situation—for example, we're having employers come in and say——

The CHAIRMAN. I'm going to ask you to keep it kind of short because I want to hear from Mr. Kampine, especially on this, and I don't want to go over my two minutes. I don't want to violate my own rule.

Mr. TIPPETS. Going to the thought that mandates—I personally believe that a very free market system, that consumers are educated and driven, is a much stronger system than mandating that something should be done.

The CHAIRMAN. Mr. Kampine, how useful are the current federal mandates on government insurance, and should there be federal mandates on the non-government insurance?

Mr. KAMPINE. So here's what I would say. All of our clients, all of our employer clients, have insurance. Many of them have transparency tools. Those transparency tools aren't used. They choose Bluebook for the ease and the effectiveness of it and the options that they have, including doing things like including cash pay bundles that might be outside of their network, which are for things like joint replacements, by definition, when I look in the claims data, significantly lower than what you would pay in the network for that hospital for that same service.

Now, we have the quality question to solve in the future. But in terms of effectiveness, I'm not sure exactly which mandates we're talking about, but in terms of insurance and access to transparency tools, really, the place where innovation has been driven here is in the private market.

The CHAIRMAN. Thank you very much.

I'm going to now go to Senator Cassidy to chair, and I'll ask Senator Scott if he'd rather let Senator Cassidy go ahead with his question or Senator Kaine, or are you ready, Senator Scott, to ask your questions?

Senator SCOTT. I'm ready.

The CHAIRMAN. Okay. We'll go to Senator—Senator Scott is always ready. So Senator Scott.

Senator SCOTT. Thank you all for being here this morning, and I truly appreciate your investment of time in looking at ways for us to help the average consumer have a better experience and, hopefully, a better price for their experience in healthcare.

In 2016, the U.S. spent about $3.3 trillion on healthcare, $3.3 trillion on healthcare. About 28 percent of those dollars came out of households. So if you think about it from a numerical perspective, that's $930 billion paid by households. The U.S. is expected to spend about $5.7 trillion on healthcare by 2026. If the current

ratio holds true, that 28 percent would represent about $1.6 trillion for the average American household.

I hope I'm pronouncing your name right, Mr. Kampine. Is that accurate?

Mr. KAMPINE. Yes.

Senator SCOTT. You estimate that $1.5 trillion of our current healthcare spending is paid for by either employers or directly by consumers, and that about $500 billion of that is spent on what you refer to as shoppable, non-acute healthcare services. If what you say is true—and I have no reason to doubt you—that when people have the tools they need to shop around for care, both consumers and employers can save 50 percent or $250 billion that they can use for all types of services——

Mr. KAMPINE. That's right.

Senator SCOTT.——expenses or savings, which would be a remarkable change as well. What steps can we take to improve the ability of consumers to shop around for such services?

Mr. KAMPINE. So, again, in our experience, in terms of working with employers, there are three things that we have found to be very, very successful. The first is education. We talked a little bit about it earlier. But when consumers know that prices vary and when they know that quality varies, they are much, much more likely, in fact, 11 times more likely to actually shop and compare providers and get better value for themselves.

So there has to be education, and it has to be consistent, because we don't consume healthcare every day. We don't think about it until later in the year when our son hurts his foot playing soccer, and then maybe we've forgotten about it. So that's sort of table stakes.

The second one is simplicity. It has to be easy for people to shop and understand what they should reasonably pay. So in my town, in my network, what is the range of prices? Is it $400 to $2,000, and if that's the range, what should I reasonably pay? And then make it very easy, and the way we do this at Bluebook is through color coding for cost and quality, but there are other methodologies for doing this. If you make it easy for consumers, once they understand, then to find those providers, they can act on that need.

The last element that I think we do find very, very effective—and over half of our clients utilize this—are value-based incentives, so, for example, cash-based incentives that encourage people to be better consumers and even encourage people when they've already met their deductible. So once you've met your deductible, for many people, where's the incentive to continue to shop for care? So cash pay incentives play a role there in terms of helping to reinforce that shopping behavior. There are other elements as well, but I would those are three.

Senator SCOTT. So just to follow up on that, if you've met your deductible, of course, your incentive for shopping goes down probably precipitously.

Mr. KAMPINE. Yes.

Senator SCOTT. However, if you have an out-of-pocket expense that still has to be met or exhausted as well, perhaps there's enough incentive for some matrix to play a role in the desire to shop if we could design it right.

Mr. KAMPINE. Yes. And, forgive me, I meant deductible and your co-insurance, or your total out-of-pocket max. But once you've reached that, it makes absolute sense. So, for example, we heard the example earlier where Mr. Tippets' ambulatory surgery center is about $17,000 for a hip replacement, or a fair price at a hospital is around $30,000. In either event, most people are going to meet their out-of-pocket max.

Additional incentive on both cost and quality, incidentally, not only on cost, but understanding which of these facilities has the best quality. It makes a lot of sense in order to offer these incentives, and they can be $500, $1,000, even larger than that, to encourage patients to make better, high-quality, cost-effective choices on their care.

Senator SCOTT. It does remind me of Secretary Azar's EKG that was mentioned earlier, $3,500 in the hospital versus $550 out of the hospital. How do we explain that type of disparity in the same market? Profit? I mean, is there another answer than that?

Mr. KAMPINE. There are a lot of different reasons for that. A lot of it has to do—and, again, there was a graph that Senator Cassidy pointed to. The facility and where you go for care is the single biggest decision. So if your cardiologist is affiliated tightly with a hospital, you stand a higher probability or a higher chance of that cardiologist referring you actually to the hospital facility, and that's how you end up with a $3,000 EKG.

So, again, this is the role for transparency. Consumers need to understand what decisions drive the cost, and how to select a doctor and keep your doctor, but make sure that you're having care in the most cost-effective venue, and most docs can do this in more than one place.

Senator SCOTT. Chairman Cassidy, if you would not mind me asking a follow-up question—my time is about out.

Senator Cassidy [presiding]. Please.

Senator SCOTT. In order for price transparency to be effective, it's also important for us to have more than simply—as you were just discussing, more than simply the price points. There's the outcome, the number of times that someone returns to the hospital based on the same doctor, same hospital, same care provider.

Can you talk for a minute or two—well, not for a minute or two, but——

Mr. KAMPINE. Fifteen seconds?

Senator SCOTT.——on the importance of that aspect, that, in fact, what consumers need to know in order for us to have a quality outcome is not the transactional expenses that are paid per transaction, but the quality of the outcome, and how that links back to the price that they paid?

Mr. KAMPINE. Absolutely. So here's how we think about it at Bluebook. Most hospitals do most services. There are very few hospitals in the U.S. that do all services equally well, and so you can't use brand as a determinant necessarily for quality. You could have a hospital that's in the top 10 percent in the U.S. for complex cardiac care and in the bottom 10 percent for joint replacement. So our obligation is to help consumers understand, when I need this particular service, what are the outcomes for the different locations I can go to.

The way we look at it, again, is specifically related to patient outcomes, and it's measured in four dimensions. One is mortality. Do patients survive the surgery? Second is complications, very important. Third are safety events, and, fourth are unanticipated readmissions. So what we want to do is collect that information and help patients understand two dimensions, right? The first is cost and quality, explained very simply, green, yellow, red, or cost, and then the second is quality, explained using the same color coding system so that both of those pieces of information can be aligned so that patients can make a good decision.

Senator SCOTT. Thank you.

Thank you for your patience, Senator.

Senator KAINE. Thank you, Senator, and again to the panel. This is a great hearing.

I want to read you an abstract of an article that was recently published by the National Bureau of Economic Research. The article is entitled "Are Healthcare Services Shoppable: Evidence From the Consumption of Lower Limb MRI Scans," and, Mr. Chair, if I could introduce this for the record.

Senator CASSIDY. Without objection.

[The information referred to follows:]

Senator KAINE. But I'm going to read you the abstract, and I'm just curious as to your thoughts about this abstract.

> "We studied how individuals with private health insurance choose providers for lower limb MRI scans. Lower limb MRI scans are a fairly undifferentiated service and providers prices routinely vary by a factor of five or more across providers within hospital referral regions. We observed that despite significant out-of-pocket cost exposure, patients often received care in high-price locations when lower-priced options were available. Fewer than 1 percent of individuals used a price transparency tool to search for the price of their services in advance of care.
>
> "The choice of provider is such that, on average, individuals bypassed six lower-priced providers between their home and the location where they received their scan. Referring physicians heavily influence where their patients receive care. The influence of referring physicians is dramatically greater than the effect of patient cost-sharing.
>
> "As a result, in order to lower out-of-pocket cost and reduce total MRI spending, patients must diverge from the established referral pathways of their referring physicians. We also observed that patients with vertically integrated, i.e., hospital-owned referring physicians are more likely to have hospital-based (and more costly) MRI scans."

Is that abstract of this piece that's just been published by the NBER consistent with your own understanding and experience?

Ms. Giunto, you look like you're ready to weigh in.

Ms. GIUNTO. Yes, Senator. I think that patients turn to their physicians for advice about where their care should be handled. I think there is often an issue of convenience, and because consumers are not used to shopping on the basis of cost, quality, or patient experience, they follow their physician's advice, and, frank-

ly, the physician may not even know the price differential of the facilities where he or she is referring.

Senator KAINE. Other thoughts?

Mr. KAMPINE. Sure. I'm very familiar with the study. I've reviewed it a couple of times for public forums and speaking engagements. A couple of things about the study. The outcomes—well, I agree that your physician plays an important role in this, and it's a huge opportunity that is yet untapped, as Nancy mentioned. And in a story that I told about Jeff's experience, doctors generally know that there's a difference in cost. They don't know exactly what that difference is, and they don't have the tools to help patients make better choices.

In the particular study, though, I think the outcome that they noted is really sort of an effect of education, education, education. So these were patients that did not use price tool, or they did, they had access to one, but it was a passive transparency program. So no education, no incentives, none of those things that help us educate patients.

One thing I took away that was very deep—nerdy guys like me read this stuff—deep in the appendix is there is a statistical analysis, and one of them shows, look, not a lot of people shopped in this instance, but the ones who did—guess what? They got lower prices for the services they consumed. So, again, we see that effect. If people know, then they shop, they get better prices—huge opportunity, though, to influence our referring physicians and make sure they have that information in their hands.

Mobile applications—somebody mentioned young people. It's easier to show it to your doctor. But I think it's a huge opportunity. We are doing some pilots. I would imagine Nancy, you are doing some pilots, and Leah as well. So a huge opportunity.

Senator KAINE. Ms. Binder, you are ready to weigh in?

Ms. BINDER. I think what the study shows is that the idea of being able to shop and not just doing what your doctor tells you, like Marcus Welby days, is a relatively new one. This is fragile new movement.

Senator KAINE. Yes. We have to fight the culture, right? There's a cultural——

Ms. BINDER. This is a massive shift in our culture. It's happening very quickly, though, I think. My feeling is that millennials, as soon as they realize they are not immortal, which means they get to be a little bit over 30 and they start to have some health problems, that is when we are going to see a transformation, because they will not tolerate the level of transparency which we have now, which really isn't where it should be.

Senator KAINE. Mr. Tippets, do you have a thought about that?

Mr. TIPPETS. Yes. One study I read is that 89 percent of individuals needing healthcare want to know what the price is, but only 26 percent actually ask their physicians, ask their doctors. They just expect that the doctor knows best, and that's why this whole movement of price transparency is so critical—educating and letting the consumer know they actually have a choice. And the doctor may or may not always know best, especially in terms of what the price would be.

Senator KAINE. But that means that price transparency is really important for physicians. I mean, it's the education of physicians about pricing as well as the education of patients.

Mr. TIPPETS. That's correct. Everybody needs to know what we're talking about, and doctors live in their own world, especially if they have their own specialties. They may not know what an MRI will be.

Senator KAINE. Right. Sure.

Mr. TIPPETS. But there are huge variances, even in small communities, in what prices would be. So just having the ability to find it in a simple manner is really critical, not just for the consumers, but the physicians as well.

Senator KAINE. Right. Thank you.

Thanks, Mr. Chair.

Senator CASSIDY. Let me build upon what Senator Kaine said, though. The typical physician cannot know what the charge is from a hospital because, frankly, the hospital doesn't know. It depends upon the insurer. It depends upon the interaction with the patient's co-insurance, et cetera.

So, Ms. Giunto, one thing I've always stressed—it can't just be the physician-patient relationship as it was with Marcus Welby, but there has to be an alignment of both the financial interest and the healthcare interest of the two parties, mutually beneficial. Are you familiar with the Direct Primary Care Model, which has been, to a certain extent, led out of Washington state?

Ms. GIUNTO. Yes, Senator.

Senator CASSIDY. Do you want to comment on that?

Ms. GIUNTO. Well, I think any time that the incentives can be aligned around care——

Senator CASSIDY. Let me just say for those who may not know, the Direct Primary Care Model, which I call the blue collar concierge—the patient pays the physician a fee per month, and the physician takes care of all those needs except those which require a referral. If the patient doesn't like it, she can terminate at any time.

So if she gets sent to the ER with a headache on Friday afternoon and spends all night there, she says, "What the heck is this doing for me?" So the doc makes a point to see her on Friday afternoon with her headache. If he does or she does refer her to a specialist, the doc then has the incentive to both look at quality and cost to make sure that she gets the best value for her relationship with the primary care.

Ms. GIUNTO. Yes. Senator, thank you, and that is exactly what I was going to say. Any time the incentives can be aligned across the care delivery systems, and participators are demanding that over the provider networks that they are engaged with, the better it is for the consumer.

Senator CASSIDY. Now, when you say that, though, you still have to have value. One of my assistants, a physician, gave the little formula: value is equal to quality divided by cost. Now, obviously, the greater the quality, the more you're willing to pay. But that becomes difficult, and one of you, Ms. Binder or Ms. Giunto, mentioned that.

But, Mr. Tippets, let me just go to the practical aspect of this. Somebody with ischemic heart disease, diabetes, and hypertension has to go in for a joint replacement. Probably, that needs to be at the general hospital. But when you have your cash price, does that cover those with various comorbidities which may require extra effort? Or is there an epi-payment upon that? I'm just asking how you would practically handle that.

Mr. TIPPETS. No. We're very sensitive, because it's not about the dollar. It's about the patient and what we can do for them. So in our policies and procedures, we're very specific on what individuals—their level of health, the ASA chart—we only accept individuals that are healthy.

Senator CASSIDY. So then let me ask—because if we had a representative of the American Hospital Association here, she would be saying, "Aha, they're cherry picking. They're taking those who are the healthiest patients, and we are left with those who are the most complicated, so, of course, we look worse both in terms of quality and cost because we do have the person with the ischemic heart disease, et cetera." How would you respond to that?

Mr. TIPPETS. Well, absolutely. Hospitals—ASCs are not anti-hospital. We recognize that we have individuals with very complex physical issues, and that hospitals and ASCs should be compensated or reimbursed for the level of complexity that a patient has. Only about 40 to 50 percent of our total hips that could be done in an outpatient setting should go to an outpatient setting because of age, diabetes, sleep apnea, any of those comorbidities. They need to go to the hospital.

Senator CASSIDY. Now, in your community, is there a differential payment based upon comorbidities?

Mr. TIPPETS. Well, we only are able—we only choose to accept patients that are——

Senator CASSIDY. I'm sorry. But the pay—if I went to the general hospital where your ASC is, would I pay more with the insurance company paying more if I had diabetes and heart disease along with my need to replace my hip, or is there the same payment for the hip replacement whether or not there are comorbidities?

Mr. TIPPET. From what I understand, the hospitals would be reimbursed more for that. But I don't know what the hospitals are reimbursed for.

Senator CASSIDY. Ms. Binder, you discussed—and I think you and Ms. Giunto as well—the difficulty in comparing different sites of care for their quality measures, and, again, a value is quality divided by cost, but quality is influenced by how sick the patient is going in. That's another complexity on that. I'm a big believer in price transparency, quality transparency, et cetera.

How do we establish value for patients so they can know if I've got something else going on, this is where I should go as opposed to there?

Ms. BINDER. Well, I think that's the information that has to be provided through transparency tools. If you're at certain risk levels, here are some options that you have in the market. I think not everybody should go to a hospital. Not everyone needs to go to a hospital, nor do they want to necessarily. That option should be avail-

able to them. We don't need to send everybody to the highest level of care.

Senator CASSIDY. You mentioned the Leapfrog initiative, that which is attempting to compile this. But also I think my staff points out that if you go to CMS, every hospital rates about the same——

Ms. BINDER. Right.

Senator CASSIDY.——and we know that there's incredible variability. So despite them amassing all this information, everybody comes out the same, a regression to the mean, if you will. So how do we actually take this and compile it in a way that I could say, "Hmm, I've got diabetes. I'd better go here as opposed to there."

Ms. BINDER. Well, I think that CMS needs to make data available to the public, which they do, behind the tool—this hospital compare, where they call everyone basically average, which is—that's the problem. But behind that is a spreadsheet——

Senator CASSIDY. Like woebegone for hospitals.

Ms. BINDER. It's worse than like—everybody's average. But behind that is a spreadsheet, and all of us, or many of us in the public arena can use that spreadsheet to populate our own tools that do show variation among providers, and that's been a very positive program, and that needs to expand. They need to be able to do that for more measures. But in their public-facing tools, because of political considerations, everybody looks average.

Senator CASSIDY. Now, Ms. Giunto, I'll finish with you. Again, you all have done a remarkable job of kind of taking all these different payers and getting information, obviously comparing different types of systems to one another. How do you all handle this issue?

Ms. GIUNTO. What we would say is that publicly available data can show distinctions. It should be severely adjusted. We haven't looked at the level of a particular case, as you've mentioned, diabetes, but we have done this at the hospital level in my state, where we've compared cost, quality, and patient experience—patient experience, not satisfaction, patient experience being how engaged in my care, how often does something happen, and we've shown through the study called the Hospital Value Report that, in fact, those hospitals in our state that are the most efficient are also among the most highest quality and have great patient experience. So we've done this in our state.

Senator CASSIDY. So high cost is, again, not necessarily correlated with better patient experience nor better outcomes.

Ms. GIUNTO. Absolutely, Senator. It does not.

Senator CASSIDY. You have found a way to address the differences between case mix, at least to a certain extent, as you compare different entities.

Ms. GIUNTO. Yes, we have. We have a long way to go, but we've made an initial attempt.

Senator CASSIDY. Thank you all very much for this, and I have a script I'm supposed to read.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like. The HELP Committee will meet again Tuesday, September 25th, for a hearing on the Every Child Succeeds Act.

Thank you for being here, particularly to our witnesses. The Committee will stand adjourned.

[Whereupon, at 11:44 a.m., the hearing was adjourned.]

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